

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910



CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT
THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE
DEPARTMENT OF Health BUREAU OF Vital
Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS
AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COM-
PLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PRO-
VIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION
NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN
ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR
ON JUNE 4, 1954.

FORM RM-1 (11-55) RETAIN—PERM.			Authorization No. 345		
REQUEST FOR RETENTION PERIOD			Department: Health		
To: Records Management Officer, Room 408, City Hall, Baltimore, 2, Md.			Bureau: Vital Statistics		
Record Identification					
1. TITLE:		2. Form No. if available		3. Type—(cards, paper, etc.)	
Certificate of Death				Bound Book	
4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made		
		Misc.	One (1)		
8. Authorization Requested (check only one (1) of the squares below)					
A. Establish retention period for <input type="checkbox"/> records which are accumulating daily.		B. Dispose of present accumulation, no additional accumulation anticipated. <input type="checkbox"/>		C. Microfilm and destroy originals. <input type="checkbox"/>	
				D. Microfilm and retain originals for length of time indicated below. <input checked="" type="checkbox"/>	
9. Recommended Retention Period			10. Equipment and space freed.		11. In your opinion does this record have any historical significance?
a. In Dept. 12 yrs. 12 yrs. b. In Storage Center and Micro. Perm. c. Total Micro. Perm.			-		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)					
<p>These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.</p> <p>RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.</p> <p>Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.</p>					
Department or Bureau Approval			<i>Robert E. Fairley, M.D.</i> Title: Commissioner of Health		Date: 3/18/63
Recommendation of Records Management Officer					
13. Recommended Retention Period			14. Disposal Method		
a. In Dept. 12 yrs. 12 yrs. b. In Storage Center and Microfilm c. Total Microfilm Permanent Permanent			A. To be sold as scrap or waste paper <input type="checkbox"/> B. To be Burned or shredded <input checked="" type="checkbox"/> C. Historical, (to be transferred to Dept. of Legislative Reference.) <input type="checkbox"/>		
REMARKS:					
<i>2 negative rolls</i>			<i>C. P. Force</i> Records Management Officer		Date: 3/18/63

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents
were received in the same
condition and microfilmed
as shown.

Every effort was made to
assure legibility and com-
pleteness.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66481

CERTIFICATE OF DEATH.

179 D 66481

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *117 N. Lanvale* ST.: *11* WARD)2-FULL NAME *Ellen Jenkins*(a) RESIDENCE. NO. *117 N. Lanvale* ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. *6* mos. ds.How long in U. S., if of foreign birth *Life time* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *(88) April 18, 1922*6 DATE OF BIRTH (month, day, and year) *Mar 1-1857*

7 AGE

Years *(94) 62*Months *71*Days *5*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *OOD*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country) *Maryland*10 NAME OF FATHER *Edmund Jenkins*11 BIRTHPLACE OF FATHER (city or town) *Maryland*
(State or country)12 MAIDEN NAME OF MOTHER *Ellen M. Buffum*13 BIRTHPLACE OF MOTHER (city or town) *Pennsylvania*
(State or country)14 Informant *Robert R. Krauter*
(Address) *117 N. Lanvale St.*15 *AUG 2-1922*ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 1* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *April 18, 1922* to *July 31, 1922*, that I last saw *her* alive on *July 31, 1922*, and that death occurred, on the date stated above, at *6 a. m.*
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(duration) 7 to my knowledge
CONTRIBUTORY *Cardiac Hypertrophy*
(Secondary) *(duration) 2 years*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*
(Signed) *R. E. Keyser*, M. D.19 (Address) *Wentworth St.*
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cem.**Aug 3rd 1922*

20 UNDERTAKER

Henry W. Jenkins Sons Co ADDRESS *Orchard*
Mc Culloch &

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

CONSULTATION HOURS
9 TO 10.30 A. M.
1 TO 2 P. M.
7 TO 8 P. M.
SUNDAY, 9 TO 10.30 A. M. ONLY

DR. R. L. KEYSER
WENTWORTH APARTMENTS
CATHEDRAL & MULBERRY STS.
BALTIMORE, MD.

C. & P. TEL.
MT. VERN.

Aug 3 - 2

Dear Sir.

On Aug 2nd I signed a
death certificate of Miss
Ellen Jenkins 119 W. Lawton
Her stated birth was given
as 1859 and it should have
been 1851. Will you please
have it corrected. I am
very sorry it happened
Thanking you in advance
I am very truly

Dr C. Hampton Jones
Health Comr.
City

R. L. Keyser

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66482

CERTIFICATE OF DEATH.

D 66482

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 D Clinton ST. 26 WARD)

2-FULL NAME

Barbara Brocklander

(a) RESIDENCE NO.

32 D Clinton St.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry Brocklander

6 DATE OF BIRTH (month, day, and year)

Aug. 18 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

611113

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Michael Reutlein

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Frankfurt

12 MAIDEN NAME OF MOTHER

Katharine Link

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mr. Henry Brocklander
326 D Clinton St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7/31 19 22

17

I HEREBY CERTIFY, That I attended deceased from 6/7/22 to 7/31/22 that I last saw her alive on 7/30/22and that death occurred, on the date stated above, at 11:30 a

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder with metastases

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. McFarrell M. D.

(Address)

633-5-3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVABLE

Oak LawnAug 4 19 22

20 UNDERTAKER

ADDRESS

Louis's Heemann 328 Broad
way

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Filed AUG 2 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66483 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2900 Springhill St. 19 Ward)

2-FULL NAME *William B. Barham*

(Residence in Baltimore: No. 1321 N. Fayette St.; yrs. 4 mos. ds.)

Registered No. C 66483

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married* (Write the word.)

6-DATE OF BIRTH, *Nov 24 1864* (Month) (Day) (Year)

7-AGE, *57* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Carpenter* (b) General nature of industry, business, or establishment in which employed (or employer), *815*

9-BIRTHPLACE, (State or Country), *Ireland*

10-NAME OF FATHER, *Clay Barham*

11-BIRTHPLACE OF FATHER, (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER, *Mary*

13-BIRTHPLACE OF MOTHER, (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Gene Barham*

(Address) *1321 N. Fayette St.*

15-

FIND

AUG 2 - 1922

RECORDED BY *RECORDED BY*

Burial Permit *CLARK*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 29 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: *Suicide Hanging*

CONTRIBUTORY (Secondary) *Alcoholism* (Duration) yrs. mos. ds.

(Signed) *W. C. Blane* (Coroner.) (Address) *1321 N. Fayette St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Trinity Cemetery 8/2/1922*

20-INTERURER, *J. J. Moran & Baltimore* ADDRESS *3000*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 66485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 66485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2308 Cambridge* ST., *1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Sophia E. Michaels*

(a) RESIDENCE NO. *2308 Cambridge*
(Usual place of abode)

ST., *1* WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *the late John P. Michaels*

6 DATE OF BIRTH (month, day, and year) *Nov. 1859*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *62*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. Md.*
(State or country)

10 NAME OF FATHER *Don't Know*

11 BIRTHPLACE OF FATHER (city or town) *Germany*
(State or country)

12 MAIDEN NAME OF MOTHER *Don't Know*

13 BIRTHPLACE OF MOTHER (city or town) *Germany*
(State or country)

14 Informant *Anna L. Campbell*
(Address) *2235 Essex St.*

15 *AUG 2 - 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 1st 1922*

17 I HEREBY CERTIFY, That I attended deceased from *July 7*, 19*22*, to *Aug. 1*, 19*22*, that I last saw her alive on *July 29*, 19*22*,

and that death occurred, on the date stated above, at *12⁴⁰ P.* m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) *Unknown* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Uremia*

(duration) *Unknown* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Laboratory*

(Signed) *Ferd. A. Ries*, M. D.

, 19 (Address) *24 S. Broadway.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto. Cemetery

DATE OF BURIAL

Aug. 5th 1922

20 UNDERTAKER

Lilly & Zien

ADDRESS

403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66486

90 D 66486

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 W. Wolfe ST., 8 WARD)

2-FULL NAME Minnie T. Schmidt

(a) RESIDENCE NO. 1605 W. Wolfe ST., 7 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of Charles Schmidt (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30th 1865
7 AGE Years 57 Months 4 Days 1 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Conrad J. Eckhardt

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary S. Gunther

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Charles Schmidt (Address) 1605 W. Wolfe St.

15 AUG 2 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31st 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 31 19 21 to July 31 19 22 that I last saw her alive on July 31 19 22

and that death occurred on the date stated above, at 5:50 P. M.

The CAUSE OF DEATH* was as follows: Urteral Regeneration

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathology

(Signed) M. D. Address 800 N. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Carmel Cem. DATE OF BURIAL Aug 3rd 1922

20 UNDERTAKER

Lilly & Ziller ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66487

113 D 66487

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 O. Donnell ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Elizabeth Clayton

(a) RESIDENCE NO. 2708 O. Donnell ST. 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Feb. 13th 1921

7 AGE Years 1 Months 5 Days 18 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town; State or country) Balto. Md.

10 NAME OF FATHER James T. Clayton

11 BIRTHPLACE OF FATHER (city or town; State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth M. Pegel

13 BIRTHPLACE OF MOTHER (city or town; State or country) Balto. Md.

14 Informant James T. Clayton
(Address) 2708 O. Donnell St.

15 File AUG 2-1922 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1922, to Aug 1, 1922.

That I last saw her alive on July 31, 1922.

and that death occurred, on the date stated above, at 6:40 a m.

The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY Dysenteria (acute)
(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. V. W. Winger M. D.

(Address) 1014 S. Elmwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal; (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sacred Heart Cem.

Aug 3rd 1922

20 UNDERTAKER

ADDRESS

Lilly & Ziehl

4033 W. 4th

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2797 Cedar Ave WARD 13)

2-FULL NAME James E Penner

(a) RESIDENCE NO. 2797 Cedar Ave WARD

(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 13 1922

7 AGE Years 6 Months 17 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) MD

10 NAME OF FATHER Elmer Penner

11 BIRTHPLACE OF FATHER (city or town) MD (State or country)

12 MAIDEN NAME OF MOTHER Nellie Vermillion

13 BIRTHPLACE OF MOTHER (city or town) MD (State or country)

14 Informant Elmer Penner (Address) 2797 Cedar Ave

15 Filed AUG 2 - 1922

ROBERT R. KRAUSE, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1922

17 I HEREBY CERTIFY, That I attended deceased from July 31 1922 to Aug 1 1922

that I last saw him alive on July 3 1922

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

(See remarks)

Gastroenteritis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY Eclampsia (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Syphilis

(Signed) R. B. Vowens M. D.

(Address) 8645 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Marys Hospital Aug 22

20 UNDERTAKER

Chenoweth & Co

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66489

CERTIFICATE OF DEATH.

113 D 66489

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 O'Donnell ST., 1 WARD)

2-FULL NAME

Joseph Adams

(a) RESIDENCE NO.

2702 O'Donnell ST., 1 WARD

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12 - 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Ind.

10 NAME OF FATHER Joseph Adams

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Ind.

12 MAIDEN NAME OF MOTHER Mario Albert

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Ind.

14 Informant Joseph Adams (Address) 2702 O'Donnell St

15 Filed Aug 2 - 1922 ROBERT R. KRAUTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1922

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1922, to Aug 1, 1922, that I last saw him alive on Aug 1, 1922, and that death occurred, on the date stated above, at 7-45 P. M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Walter J. Darrach, M. D.

, 19 (Address) 3035 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Rosary Cemetery

20 UNDERTAKER

L. J. Ziehl

DATE OF BURIAL

Aug 2 1922

ADDRESS

4038 N. ...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66490

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 S. 14th St. ST., 76 WARD)

2. FULL NAME

Maris E. Richter

(a) RESIDENCE NO. 325 S. 14th St. ST., 76 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 - 1922

7 AGE Years Months Days If LESS than 1 day, hrs or min. 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Ignatius Richter

11 BIRTHPLACE OF FATHER (city or town) Balto Md. (State or country)

12 MAIDEN NAME OF MOTHER Anna M. Richter

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Ignatius Richter (Address) 325 S. 14th St.

15 AUG 2 - 1922 ROBERT R. KNAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 22, 1922, to Aug 1st, 1922.

that I last saw him alive on July 31st, 1922.

and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cev.

DATE OF BURIAL

Aug. 1 1922

20 UNDERTAKER

Lilly & Ziehl

ADDRESS

403 S. W. 1st

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No gastro enteritis
Congenital Debility
Mother 48 yrs.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66491

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. ... (WARD)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1922

17

HEREBY CERTIFY, That I attended deceased from
July 31st, 1922, to August 11th, 1922
that I last saw him live on July 31st, 1922

and that death occurred, on the date stated above, at 7:00 P. m

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — ds

18 Where was disease contracted if not at place of death? *At place of death*

Did an operation precede death? ☐ Yes ☐ No Date of

Was there an autopsy?

What test confirmed diagnosis? *Physical Examination*
 (Signed) *Harley H. Hatcher* M.D.

8/2 1922 (Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Cedar Hill Cemetery

DATE OF BURIAL

1922

ADDRESS

X30 E. Ferry

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66492 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D 66492

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Celia Thomas

(a) RESIDENCE No. 1036 N. Stockton St. ST., 16 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE Years 64 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Wm. Baal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records, (Address) Municipal Hospital

15 AUG 2-1922 ROBERT H. KRAUTER, Registrar Burial Permit Check

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 21, 19 22 to July 31, 19 22, that I last saw her alive on July 31, 19 22, and that death occurred, on the date stated above, at 10:45 A.M.. The CAUSE OF DEATH* was as follows:

Syphilis

CONTRIBUTORY (Secondary) Chronic nephritis (duration) 44 yrs. 0 mos. 0 ds. (duration) 20 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray Urine etc (Signed) Clyde McNeil, M. D.

8/1/1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

At Auburn

20 UNDERTAKER

Samuel W. Chase - son

DATE OF BURIAL

8/2/22 19

ADDRESS

1450 North St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66493

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *569 Presstman* ST.: *14* WARD)REGISTERED NO. *66493*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Emma Tallman*(a) RESIDENCE. NO. *569 Presstman* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *45* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *C* 5 Single, Married, Widowed, or Divorced (write the word) *widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *unknown*7 AGE Years *63* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Na*10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *"*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *"*14 Informant *John Tallman* (Address) *569 Presstman*

15 Filed

AUG 2-1922

ROBERT R. KRAUTH

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *July 31* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *June 26*, 19*22*, to *July 31*, 19*22*, (that I last saw him alive on *July 31*, 19*22*, and that death occurred, on the date stated above, at *1130 P.* m.

The CAUSE OF DEATH* was as follows:

Intermittent Nephritis (duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *no*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *urinalysis*(Signed) *H. S. McCard* M. D., 19 (Address) *2005 Druid Hill Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Paul's A. M. Church *Aug 3* 19*22*

20 UNDERTAKER

George H. Holland *631*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66494

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1616 Druid Hill Ave ST.: 14 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary K. Henderson

(a) RESIDENCE. No. 1616 Druid Hill Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced Widowed of Frank Henderson (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12, 1891

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
30 8 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Joseph Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Victoria May

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant John Henderson (Address) 1616 Druid Hill Ave

15 Filed AUG 2-1922 19 ROBERT R. KRAUT Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1922

17 I HEREBY CERTIFY, That I tended deceased from

Feb 1, 1922, to Aug 1, 1922,

that I last saw him alive on July 30, 1922,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis
(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCard M. D.

811, 1922 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Cemetery Aug 3 1922

20 UNDERTAKER ADDRESS

George F. G. Gibson 1344 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66495

CERTIFICATE OF DEATH.

D 66495

1-PLACE OF DEATH

Bay View Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Mary Reinhardt

(a) RESIDENCE NO.

746 Foundry Court

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

John P. Reinhardt

6 DATE OF BIRTH (month, day, and year)

1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Philip Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Busan Sherman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

John P. Reinhardt 746 Foundry Court

15

AUG 2 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

7-30 1922

17

I HEREBY CERTIFY, That I attended deceased from

7-18 1922, to 7-30 1922.

that I last saw him alive on 7-30 1922.

and that death occurred, on the date stated above, at 345a.m.

The CAUSE OF DEATH* was as follows:

Spinal Chord tumor at level of 1st & 2nd dorsal vertebra

(duration)

yrs.

8 mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

1/2 ds.

Post operative Shock.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-29-22

Was there an autopsy? Yes

What test confirmed diagnosis?

Examination

(Signed)

Richardson Jones, M. D.

, 19

(Address)

Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Zion Cemetery Howard Co

UNDERTAKER

Robt J. Turner Inc

DATE OF BURIAL

Aug 2 1922

ADDRESS

44 Broadway.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66496

CERTIFICATE OF DEATH.

Registered No. C. 66496

1-PLACE OF DEATH

City of BALTIMORE: (No. *St Agnes Hospital* St. *20* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William C. Willhauer*

(Residence in Baltimore: No. *618 S. Payson* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, *Married* (Write the word.)

6-DATE OF BIRTH, *Oct 25*, 1898 (Month) (Day) (Year)

7-AGE, *23* yrs. *9* mos. *6* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Smoker 086* (b) General nature of industry, business, or establishment in which employed (or employer), *Meat Packing Co.*

9-BIRTHPLACE, (State or Country), *Bolt City*

10-NAME OF FATHER, *Frederick Willhauer*

11-BIRTHPLACE OF FATHER, (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Mabel Doughton*

13-BIRTHPLACE OF MOTHER, (State or Country), *Harford Co.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Laura Gentry*

(Address) *30 11 Mount St*

15 AUG 2-1922

ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 1*, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. *Autopsy* (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said. *Autopsy* (Inquest, autopsy or Inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Lacerated Brain, Compound fracture of Elbow, fall down elevator shaft, accident* (Duration) yrs. mos. ds.

CONTRIBUTORY *Double Lobar Pneumonia* (Secondary) (Duration) yrs. mos. ds.

(Signed) *James M. Wilson* M. D. (Coroner.) *July 21 1922* (Address) *700 E. Chase St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, *Harford Co.* In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? *Wilson & Martin meat packing Co.* Former or usual residence *618 S. Payson St.*

19-PLACE OF BURIAL OR REMOVAL, *Jarrettsville Md* DATE OF BURIAL, *Aug 3*, 1922

20-UNDERTAKER, *Harry H. Amos* ADDRESS, *4704 Ridgewood Ave.*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66497

CERTIFICATE OF DEATH.

161-081 66497

1-PLACE OF DEATH 15 W. Barre St.
CITY OF BALTIMORE: (No. Baltimore Md ST. 22 WARD)
2-FULL NAME Baby Edley
(a) RESIDENCE NO. 15 W. Barre ST. 22 WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-30-22

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
0 0 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

10 NAME OF FATHER Clifton Edley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Anna May Wray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14

Informant (Address)

Robert T. Harrison,

15

AUG 2 - 1922

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-22

17

I HEREBY CERTIFY, That I attended deceased from 7-30-1922, to 7-31-1922, that I last saw her alive on 7-31-1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature (foetus)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Howard R. Tolson, M.D.

, 19

(Address) 1325 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

JOHN H. HOPKINS HOSPITAL

DATE OF BURIAL

AUG 2 1922

20 UNDERTAKER

ADDRESS

Commissioner Health,

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66498

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66498

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1335 Argyle Ave ST. 17 WARD)

2-FULL NAME Martha Anderson

(a) RESIDENCE NO. 1335 Argyle Ave ST. 17 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced

HUSBAND WIFE of

Howard Anderson

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE: Years 27 Months 07 Days 09 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER W. B. Johnson

11 BIRTHPLACE OF FATHER (city or town) Oh (State or country)

12 MAIDEN NAME OF MOTHER Howard 1x

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Howard Anderson (Address) 1335 Argyle Ave

15 UG 2-1922 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1922 to July 31, 1922

that I last saw him alive on July 30, 1922 and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows:

Prenatal Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY

Renal disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Lee Ellis, M. D.

8/1, 1922 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Auburn Cemetery

DATE OF BURIAL

20 UNDERTAKER

J. M. Johnson

ADDRESS 1234

Etting St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66499

CERTIFICATE OF DEATH.

29 D 66499

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Ashland Ave ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emil Vachal

(a) RESIDENCE. NO.

1630 Ashland Ave ST.: 7 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred half yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 27, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

Emmanuel Vachal

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Anna Kozak

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

14

Informant (Address)

Emmanuel Vachal1630 Ashland Ave

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 31, 1922, to Aug 27, 1922,that I last saw him alive on Aug 12, 1922,and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Trauma Mucobrom

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chas B. Fugler M. D.

192 (Address)

830 W Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy RedeemerAug 3, 1922

20 UNDERTAKER

ADDRESS

Frank Brockton1906 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG 2-1922

Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66500

CERTIFICATE OF DEATH.

D 66500

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Pennington Ave ST. 25 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1114 Pennington Ave ST. 25 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If nonresident give city or town and State)
How long in U. S., if of foreign birth? 20 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Horvick

6 DATE OF BIRTH (month, day, and year) not known

7 AGE Years 54 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

10 NAME OF FATHER Adam Horvick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Annie Lepus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Louis Kardor (Address) 1114 Pennington Ave

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1st 1922

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1922, to Aug. 1st, 1922, that I last saw him alive on Aug. 1st, 1922, and that death occurred, on the date stated above, at 4:55 p.m.

The CAUSE OF DEATH* was as follows:

Septic Poisoning

CONTRIBUTORY (Secondary)

Infected hand (duration) 5 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. B. Horton M. D.

(Address) Curtis Bay, Balto

State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill

Aug. 3 1922

20 UNDERTAKER

ADDRESS

Frank Pracht & Son 1906 Barks

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66501

CERTIFICATE OF DEATH.

90 D 66501

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Harris St. WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Pazdan

(a) RESIDENCE. No.

909 Harris St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

Josephine

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 49 Months 4 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Fertilizing industry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

John Pazdan 909 S. Harris Alley

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 31, 1922 to July 31, 1922.
that I last saw him alive on July 31, 1922.and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos. ds.

CONTRIBUTION

(Secondarily)

Chronic Valvular Heart Disease duration several yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical signs(Signed) D. B. Brownish M. D.8-1-1922 (Address) 3037 Edmond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Church Aug 3 1922

20 UNDERTAKER

ADDRESS

Stephen J. Harkovsk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 2 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66502

CERTIFICATE OF DEATH.

31 D 66502

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

238 S. Bouldin

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Michael F. Hagan

(a) RESIDENCE. No.

238 S. Bouldin

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Minnie Hagan

6 DATE OF BIRTH (month, day, and year)

Sept 17, 1878

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

50

10

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman oil

(b) General nature of industry, business, or establishment in which employed (or employer)

Del. Truck

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Bernard Hagan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary McKim

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland.

14

Informant (Address)

Minnie Hagan 238 S. Bouldin

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

July 30, 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1922, to July 30, 1922.

that I last saw him live on July 29, 1922.

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary

CONTRIBUTORY (Secondary)

(duration)

yrs.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. S. Smith

M. D.

(Address)

3323 E. Baltimore

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn,

DATE OF BURIAL

Aug 3, 1922

20 UNDERTAKER

John H. Moran 3000 E. Baltimore

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G. 2-1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 66503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)

6-DATE OF BIRTH, 1 (Month) (Day) (Year)

7-AGE, about 38 or 40 It LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Struct. Iron (b) General nature of industry, business, or establishment in which employed (or employer). work.

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) John Dept (Address)

15- Robert P. Harrison, 101. Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 1, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Trauma of skull - probably fractured chest crushed accidentally from fall from a bridge

CONTRIBUTORY (Secondary) Shed (Duration) yrs. mos. ds. (Signed) Arthur (Coroner) M. D. Aug 2, 1922 (Address) 16 39 22

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cramford, N. J. DATE OF BURIAL, Aug 2nd, 1922 20-UNDERTAKER, E. J. Fanning ADDRESS, Ann-1938 E. Lafayette Ave

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Due to fall

*copy of 11 of 16
Hogrop 107*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66505

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Hollins

ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anna Stouffer

(Residence in Baltimore: No. 1620 Hollins

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Widowed

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE.

64

yrs. — mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Home

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

Solomon Barnes

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Providencia Bruthus

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Arthur Federline

(Address)

1620 Hollins

15 AUG 3 - 1922

ROBERT R. KRAUTER,

Filed..... 191.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 2, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 2 1922, to Aug 2 1922,

that I saw her alive on Aug 2 1922,

and that death occurred, on the date stated above, at 10:10 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart trouble

(Duration) 3 yrs. mos. ds.

(Signed) Chas. A. Schaper M. D.

Aug 2, 1922 (Address) 521 E. Bolton Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Westminster

DATE OF BURIAL,

Aug 5, 1922

20-UNDERTAKER

H. Bankard & Son

ADDRESS

Westminster

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

179

3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Richard A. Hammond

WARD

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1922

17 I HEREBY CERTIFY, That I attended deceased from

Feb. 2, 1922 to Aug. 2, 1922

that I last saw him alive on Aug. 2, 19 20

and that death occurred on the date stated above, at..... m

The CAUSE OF DEATH* was as follows:

1130

Handwritten: *Handwritten*

(duration) yrs mos 2 ds

CONTRIBUTORY *Chronic intermittent*

CONTRIBUTORY (Secondary) *Chronic* *3* *mo* *6* *mo* *1* *yr* *2* *yr* *3* *yr* *4* *yr* *5* *yr* *6* *yr* *7* *yr* *8* *yr* *9* *yr* *10* *yr* *11* *yr* *12* *yr* *13* *yr* *14* *yr* *15* *yr* *16* *yr* *17* *yr* *18* *yr* *19* *yr* *20* *yr* *21* *yr* *22* *yr* *23* *yr* *24* *yr* *25* *yr* *26* *yr* *27* *yr* *28* *yr* *29* *yr* *30* *yr* *31* *yr* *32* *yr* *33* *yr* *34* *yr* *35* *yr* *36* *yr* *37* *yr* *38* *yr* *39* *yr* *40* *yr* *41* *yr* *42* *yr* *43* *yr* *44* *yr* *45* *yr* *46* *yr* *47* *yr* *48* *yr* *49* *yr* *50* *yr* *51* *yr* *52* *yr* *53* *yr* *54* *yr* *55* *yr* *56* *yr* *57* *yr* *58* *yr* *59* *yr* *60* *yr* *61* *yr* *62* *yr* *63* *yr* *64* *yr* *65* *yr* *66* *yr* *67* *yr* *68* *yr* *69* *yr* *70* *yr* *71* *yr* *72* *yr* *73* *yr* *74* *yr* *75* *yr* *76* *yr* *77* *yr* *78* *yr* *79* *yr* *80* *yr* *81* *yr* *82* *yr* *83* *yr* *84* *yr* *85* *yr* *86* *yr* *87* *yr* *88* *yr* *89* *yr* *90* *yr* *91* *yr* *92* *yr* *93* *yr* *94* *yr* *95* *yr* *96* *yr* *97* *yr* *98* *yr* *99* *yr* *100* *yr* *101* *yr* *102* *yr* *103* *yr* *104* *yr* *105* *yr* *106* *yr* *107* *yr* *108* *yr* *109* *yr* *110* *yr* *111* *yr* *112* *yr* *113* *yr* *114* *yr* *115* *yr* *116* *yr* *117* *yr* *118* *yr* *119* *yr* *120* *yr* *121* *yr* *122* *yr* *123* *yr* *124* *yr* *125* *yr* *126* *yr* *127* *yr* *128* *yr* *129* *yr* *130* *yr* *131* *yr* *132* *yr* *133* *yr* *134* *yr* *135* *yr* *136* *yr* *137* *yr* *138* *yr* *139* *yr* *140* *yr* *141* *yr* *142* *yr* *143* *yr* *144* *yr* *145* *yr* *146* *yr* *147* *yr* *148* *yr* *149* *yr* *150* *yr* *151* *yr* *152* *yr* *153* *yr* *154* *yr* *155* *yr* *156* *yr* *157* *yr* *158* *yr* *159* *yr* *160* *yr* *161* *yr* *162* *yr* *163* *yr* *164* *yr* *165* *yr* *166* *yr* *167* *yr* *168* *yr* *169* *yr* *170* *yr* *171* *yr* *172* *yr* *173* *yr* *174* *yr* *175* *yr* *176* *yr* *177* *yr* *178* *yr* *179* *yr* *180* *yr* *181* *yr* *182* *yr* *183* *yr* *184* *yr* *185* *yr* *186* *yr* *187* *yr* *188* *yr* *189* *yr* *190* *yr* *191* *yr* *192* *yr* *193* *yr* *194* *yr* *195* *yr* *196* *yr* *197* *yr* *198* *yr* *199* *yr* *200* *yr* *201* *yr* *202* *yr* *203* *yr* *204* *yr* *205* *yr* *206* *yr* *207* *yr* *208* *yr* *209* *yr* *210* *yr* *211* *yr* *212* *yr* *213* *yr* *214* *yr* *215* *yr* *216* *yr* *217* *yr* *218* *yr* *219* *yr* *220* *yr* *221* *yr* *222* *yr* *223* *yr* *224* *yr* *225* *yr* *226* *yr* *227* *yr* *228* *yr* *229* *yr* *230* *yr* *231* *yr* *232* *yr* *233* *yr* *234* *yr* *235* *yr* *236* *yr* *237* *yr* *238* *yr* *239* *yr* *240* *yr* *241* *yr* *242* *yr* *243* *yr* *244* *yr* *245* *yr* *246* *yr* *247* *yr* *248* *yr* *249* *yr* *250* *yr* *251* *yr* *252* *yr* *253* *yr* *254* *yr* *255* *yr* *256* *yr* *257* *yr* *258* *yr* *259* *yr* *260* *yr*

18 Where was disease contracted

if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? *urinalysis*

(Signed) A. T. Armistead, M. I.

, 19 (Address) 7 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Cause

state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
--------------------------------------	----------------

MOVAL
J. S. Wood
8/5 192

20 UNDERTAKER ADDRESS

Yours Cook

11. 3. 75

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Ills.

D 66507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5722 York Road. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eleanor Davis

(Residence in Baltimore: No. 5722 York Road. St. 57 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F. 4-COLOR OR RACE. W. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widowed

6-DATE OF BIRTH. July 7, 1892, 1 (Month) (Day) (Year)

7-AGE. 30 yrs. mos. ds. 17-LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. St. Home job. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Scotland

10-NAME OF FATHER. Wm. Woodbell

11-BIRTHPLACE OF FATHER (State or Country). Scotland

12-MAIDEN NAME OF MOTHER. Letitia Vandout

13-BIRTHPLACE OF MOTHER (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Davis

(Address) 14 E. Lex. St.

15-AUG 3-1922 ROBERT R. KRAUTER,

Filed 191... Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 1, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to Aug 1, 1922, that I saw her alive on July 31, 1922, and that death occurred, on the date stated above, at 7:10 am.

The CAUSE OF DEATH* was as follows:

Fall, July 19, 1922. Indurated R. Maxilla. Injury to throat & neck.

(Duration) yrs. mos. ds. 13

CONTRIBUTORY (Secondary) Just age

(Duration) yrs. mos. ds.

(Signed) J. H. Crookings M. D.

5835 York Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Greenmount

DATE OF BURIAL, Aug 3, 1922

20-UNDERTAKER, Wm. Cook

ADDRESS, 502 E. North

(Over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66508

D 66508

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Southern Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2520 Greenmount Ave. 10 WARD)

2-FULL NAME

Mrs. Minnie Wilmina Wilson

(a) RESIDENCE NO.

4-6. Cor. Eager & Valley.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Do not know.

6 DATE OF BIRTH (month, day, and year)

not known

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Heim

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Mammie Trainor
Baltimore, Md.

15

AUG 3-1922

Bertal Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 2nd 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 13, 1922, to Aug. 2, 1922,

that I last saw him alive on Aug. 2, 1922,

and that death occurred, on the date stated above, at 7:40 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma rectum

CONTRIBUTORY (Secondary)

(duration) 12 yrs. mos. ds.

Paralysis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Dudley P. Rowe, M. D.

, 19

(Address)

904 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MORAL

20 UNDERTAKER

Wm. Cook

DATE OF BURIAL

Aug 4 1922

ADDRESS

502 E North

for

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66509

CERTIFICATE OF DEATH.

31 D 66509

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 556 Oxford St. ST., 17 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lee Schaffer

(a) RESIDENCE NO. 556 Oxford St. ST., _____ WARD _____
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther Schavers

6 DATE OF BIRTH (month, day, and year) July 6, 1899

7 AGE 23 Years _____ Months _____ Ds. If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) va

10 NAME OF FATHER William Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) va

12 MAIDEN NAME OF MOTHER Radia Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) va

14 Informant Robert Randall
(Address) 556 Oxford St.

15 AUG 3 - 1922 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1 - 1922

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922 to Aug. 1 - 1922 that I last saw her alive on Aug. 1 - 1922 and that death occurred, on the date stated above, at 10:10 A.M.

The CAUSE OF DEATH* was as follows:
Haemorrhage of Lungs.
Tuberculosis of Lungs
(duration) _____ yrs. _____ mos. 1 da.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs
(duration) _____ yrs. 3 mos. _____ da.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Health Department
(Signed) Dr. J. H. K. Marshall, M. D.
19 (Address) 556 Oxford St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Auburn

DATE OF BURIAL

Aug 3 1922

20 UNDERTAKER

John H. Owens

ADDRESS

556 Oxford St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

107037.

HEALTH DEPARTMENT—CITY OF BALTIMORE

002
D 66510

D 66510

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, 73 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Evelyn Hetter

(a) RESIDENCE NO. 133 Henrietta St. WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Edith Hetter (mother)

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1920

7 AGE 1 Years 7 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child, jr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Maryland

10 NAME OF FATHER

Charles Hetter

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Edith Bond

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

AUG 3 - 1922

ROBERT R. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1922

17 I HEREBY CERTIFY, That I attended deceased from

July 7, 1922, to July 31, 1922.

that I last saw her alive on July 31, 1922,

and that death occurred, on the date stated above, at 4:45 A. M.

The CAUSE OF DEATH* was as follows:

Peritonitis (Chr adhesive)
not tubercular

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia (unresolved)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

Date of

Was there an autopsy?

Yes.

What test confirmed diagnosis?

Autopsy

(Signed)

Wesley B. Mason, M. D.

8/1/1922 (Address)

H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

St. Auburn

Aug 3, 1922

20 UNDERTAKER

John H. Trudine

ADDRESS 142

W. Steel

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Named Dr. Mann who said that the pericardium was found P. M. and that the Pneumonia was probably the primary cause.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—150 Bks.

D 66511

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 867 Pierce ST., 11 WARD)

2-FULL NAME

(a) RESIDENCE NO. 867 Pierce St. ST., 11 WARD

(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 11 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced Widowed of Jennie Gray

6 DATE OF BIRTH (month, day, and year) Jul 1873

7 AGE Years 49 Months 3 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping

(c) Name of employer Whispering SS Co.

9 BIRTHPLACE (city or town) Calvert County (State or country) Md.

10 NAME OF FATHER Joseph Gray

11 BIRTHPLACE OF FATHER (city or town) Calvert (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Parker

13 BIRTHPLACE OF MOTHER (city or town) Calvert (State or country) Md.

14 Informant Norman Jackson (Address) 867 Pierce St.

15 AUG 3 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1922 to Aug 1, 1922 that I last saw him live on July 31, 1922 and that death occurred, on the date stated above, at 12:25 m. The CAUSE OF DEATH* was as follows:

Acute Endocarditis
(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?
(Signed) W. H. H. H. H. H. M. D.
, 19 (Address) 119 N. Carroll St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

Forest Home Cal. Aug 3 1922

20 UNDERTAKER ADDRESS 142

John H. Treadwell uskill

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66512

CERTIFICATE OF DEATH.

REGISTERED NO.

66512

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *1718 Carter* ST. *12* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Heleen Jennette Batty*(a) RESIDENCE. NO. *1718 Carter* ST. *12* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 16/1922*7 AGE Years Months Days *17* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*10 NAME OF FATHER *Wm Batty*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*12 MAIDEN NAME OF MOTHER *Florence Lane*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md*14 Informant *Florence Batty* (Address) *1718 Carter St*15 *AUG 3-1922* ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 2 1922*17 I HEREBY CERTIFY, That I attended deceased from *July 16*, 1922, to *Aug 2*, 1922,that I last saw him alive on *July 31*, 1922,and that death occurred, on the date stated above, at *7 a* m.

The CAUSE OF DEATH* was as follows:

Pneumonia BIRTH.(duration) yrs. mos. *16* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Louis E. Johnson*, M. D.19 (Address) *211-E-23rd St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS *Laurel Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Stanczyk
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66513

D 66513

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 Alice Anna ST., 2 WARD)

2-FULL NAME

Stephen Stanczyk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1916 Alice Anna

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 8 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 1921

7 AGE Years 7 Months 29 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Joseph Stanczyk

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Antonina Trificko

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Joseph Stanczyk (Address) 1916 Alice Anna

15 AUG 3 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1922

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1922, to Aug. 2, 1922, that I last saw him alive on Aug 1, 1922,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoe

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary)

Malnutrition

(duration) yrs. mos. 35 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rohrbacher, M. D.

, 19 (Address) 1709 Alice Anna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

Holy Rosary Aug 3 1922 John M. Weber 1803 Bank

D 66514 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1569 Richland ST., 13 WARD)

2-FULL NAME

Albert Gross Jr.(a) RESIDENCE NO. 1569 Richland ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE Wht 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 22/217 AGE Years Months Days If LESS than 1 day, hrs. or min.
one 2 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)10 NAME OF FATHER Albert Gross11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)12 MAIDEN NAME OF MOTHER Myrtle Corill13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)14 Informant Albert Gross
(Address) 1569 Richland15 AUG 3 - 1922 ROBERT R. KRAUTER
Registral

Burlat Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1922

17

I HEREBY CERTIFY, That I attended deceased from July 27, 1922 to Aug 14, 1922, that I last saw him alive on Aug 1, 1922, and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Malnutrition & Diarrhoea
Very acute from birth

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Viscid(Signed) E. J. Smith, M. D.8/1, 1922 (Address) 1605 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park Aug 1, 1922
George J. Smith

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66515

CERTIFICATE OF DEATH.

160 D 66515
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (Not JOHNS HOPKINS HOSPITAL ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anthony Linbaum

(a) RESIDENCE NO.

2113 W. Vine St.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown

ds.

How long in U. S., if of foreign birth?

yes yrs. no mos. no ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 2-1922

7 AGE

Years

Months

Days

—4—If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Maryland

10 NAME OF FATHER

Edward Linbaum11 BIRTHPLACE OF FATHER (city or town)
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Stine Herby13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Maryland

14

Informant
(Address)JOHNS HOPKINS HOSPITAL

15

AUG 3 - 1922ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 2 19 22

17

I HEREBY CERTIFY, That I attended deceased from

8-1-1922 19 22, to Aug 2 19 22.that I last saw him alive on Aug 2 19 22.and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Malnutrition cause?18 Where was disease contracted
if not at place of death?CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? —(Signed) T.B. Gay, M. D.19-2, 1922 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALCathedral Ave

DATE OF BURIAL

8/3/22

20 UNDERTAKER

Mr A. E. S. Sutor

ADDRESS

1000

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Fulwood

(a) RESIDENCE NO.

18 E. Twentieth

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

—

8

?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundry

(b) General nature of industry, business, or establishment in which employed (or employer)

Body

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Sam Fulwood

11 BIRTHPLACE OF FATHER (city or town) (State or country)

S.C.

12 MAIDEN NAME OF MOTHER

Jennie McWaller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

AUG 3 - 1922

Burial Permit Check

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 26 - 1922 to Aug 2 1922

that I last saw him alive on Aug 2 1922

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery, acute

(duration) yrs. 1 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Stool culture

(Signed)

T. B. Gay

M. D.

, 19

(Address)

Johns Hopkins Hosp

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Lincoln Burg S.C.

DATE OF BURIAL

Aug 4 1922

20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS 1725 -

Ashland St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66517

CERTIFICATE OF DEATH.

179 D 66517

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Christ's Institution Hospital* ST. *704 Ensor St* WARD *8*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna E. Ward

(a) RESIDENCE No.

1602 N. Dallas

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *12* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Caucasian* 5 *Single, Married, Widowed, or Divorced, (write the word)* *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *H/c*

6 DATE OF BIRTH (month, day, and year) *Sept. 1, 1883*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *39*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Wife*

(b) General nature of industry, business, or establishment in which employed (or employer) *House Wife*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Lain! - Marys C*

10 NAME OF FATHER *Richard Gault*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14 Informant (Address) *Mrs Robert A Elliott 1725 Ashland St*

15 Filed *ROBERT R. KRAUTER, Registrar* *AUG 3 - 1922*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 1, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *April 13, 1922* to *Aug. 1, 1922* that I last saw her alive on *Aug. 1, 1922* and that death occurred, on the date stated above, at *7:30 A.m.*

The CAUSE OF DEATH* was as follows:

Apoplexy
Chronic Bright Disease + Asthma + Dropsy (duration) yrs. mos. ds.

CONTRIBUTORY *Chronic Bright Disease + Asthma + Dropsy* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *1602 N. Dallas St*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *L. W. Remond*, M. D.

8-1, 1922 Address *708 Ensor St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

DATE OF BURIAL

Aug 3 1922

20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS *1725 Ashland St*

Missing
#D 66518

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Ills.

D 66519

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66519

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 Maryland Ave. (Westport) 25 WARD)

2-FULL NAME Dennis V. Mc. Culiffe

(a) RESIDENCE. No. 237 Maryland Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21, 1921

7 AGE Years 1 Months 1 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Dennis V. Mc. Culiffe

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)

12 MAIDEN NAME OF MOTHER Annie Hall

13 BIRTHPLACE OF MOTHER (city or town) North Dakota (State or country)

14 Informant (Address) Dennis V. Mc. Culiffe 237 Maryland Ave. Westport

15 File AUG 3 - 1922 ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1922, to Aug. 2, 1922,

that I last saw him alive on Aug. 2, 1922,

and that death occurred, on the date stated above, at 2:20 p. m.

The CAUSE OF DEATH* was as follows:

Heart - Intoxication (duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. J. Marr, M. D.

8.3. 1922 (Address) 811 N. ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Ceme. 8/4 22

20 UNDERTAKER ADDRESS

Gen. Degnan & Son 1400 1 Poca W

D 66520 HEALTH DEPARTMENT—CITY OF BALTIMORE 164 66520

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1725 Barclay

ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Michael J. Moore

(Residence in Baltimore: No. 1725 Barclay

St.; yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

57

yrs.

mos.

da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry, business, or establishment in which

employed (or employer)

P. Police

9-BIRTHPLACE,
(State or Country),

Balt. Md.

PARENTS.

10-NAME OF FATHER,

Cornelius Moore

11-BIRTHPLACE OF FATHER
(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rose Moore

(Address)

1725 Barclay St.

15-

AUG 3 - 1922

Filed

101

J. W. Wynn

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug.

(Month)

12

(Day)

1922

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan. 1910, to Aug. 1922

that I saw him alive on July 31, 1922

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Suppurating Ulcer-Chronic - on top, has been ridden 8 yrs. no other complication except from ulcer & age infirmities

(Duration) 8 yrs. mos. da.

CONTRIBUTORY Age & general weakness (Secondary)

(Signed) J. B. Gallaway, M. D.

101 (Address) 318 E. Hanover St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Joseph's Church, Aug. 4, 1922

20-UNDERTAKER

ADDRESS

Margaret E. Flynn 1422 Light St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Rhs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66521

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3728 Monastery Ave

ST.,

WARD)

2-FULL NAME Eva May Kircher

(a) RESIDENCE NO. 3728 Monastery Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single~~ Married, Widowed, Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

George G. Kircher

6 DATE OF BIRTH (month, day, and year) March 10th, 1889

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

33

4

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

Maryland

10 NAME OF FATHER

George Childs

11 BIRTHPLACE OF FATHER (city or town)

Balto.

(State or country)

Md.

12 MAIDEN NAME OF MOTHER Harriet A. Degaw

13 BIRTHPLACE OF MOTHER (city or town)

Balto.

(State or country)

Md.

14

Informant
(Address)

George G. Kircher

3728 Monastery Ave

15

AUG 3 - 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1st, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 24, 1922, to Aug 1, 1922,

that I last saw her alive on Aug 1, 1922,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial

Insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

Valvular Heart Disease
not definitely known

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones, M. D.

8-2-1922 (Address)

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Loudon Park Cemetery

August 4, 1922

20 UNDERTAKER

ADDRESS

Wartman & Co

1723 W. Lafayette
etc etc

D 66522

HEALTH DEPARTMENT—CITY OF BALTIMORE

66522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO 1109 Wilcox

ST. 10

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret Crowley

(a) RESIDENCE

NO 1109 Wilcox

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs.

mos.

ds. How long in U. S., if of foreign birth? 56 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of

Patrick Crowley

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 8

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Mark Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14 Informant

(Address)

Mr. Crowley 1109 Wilcox

AUG 3 - 1922

ROBERT J. KAUFER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1922

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1922, to Aug 1, 1922,

that I last saw her alive on Aug 1, 1922, and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus End of Stomach

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. 20 ds. Stomach Pylorus

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) James M. Reardon M. D. 82, 1922 Address 7006 Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Aug 4 1922

20 UNDERTAKER

H. C. Wiedefeld 914 Green Mt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66523

HEALTH DEPARTMENT—CITY OF BALTIMORE D 66523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *412 N. Green* ST., *17* WARD)

2-FULL NAME

Salvatore Di Vincenzo

(a) RESIDENCE NO.

412 N. Green

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred *44* yrs. *35* mos. *44* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec. 15, 1850*7 AGE *71* Years *8* Months *18* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy
Giuseppe Francesco Di Paolo

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Italy*
Marie G. Di Paolo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Cosimo Di Vincenzo
412 N. Green St.

15

AUG 3 - 1922

ROBERT R. KRAUTER,

Registrar
Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8-2-1922*

17

I HEREBY CERTIFY, That I attended deceased from *July 15, 1922* to *July 19, 1922* that I last saw her alive on *July 19, 1922* and that death occurred, on the date stated above, at *99, m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

9-3-22

Address

S. J. Emarco, M. D.
1604 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral Cemetery**8/4/1922*

20 UNDERTAKER

George J. Ruth

ADDRESS

*1735 Harford Ave*MARGIN RESERVED FOR STANDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

66524

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66524

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *179*)

2 FULL NAME

(Residence in Baltimore: No. *2528 Hollins*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. *50* yrs. *5* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Feb.

28, 1857

(Month)

(Day)

(Year)

7 AGE

65

5

3

ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Butcher

113

9 BIRTHPLACE (State or country)

Germany

PARENTS

10 NAME OF FATHER

Carnest Hattenbacher

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Kathy Fuchs

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary L. Hattenbacher

(Address)

2528 Hollins St.

15

AUG 3 - 1922

Filed *1922*

ROBERT R. KRAUTER

Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Aug

2, 1922

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 1, 1922, to Aug 2, 1922.

that I saw him alive on *Aug 1, 1922.*

and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH* was as follows:

Atherosclerosis - High blood pressure - Myocarditis - Chronic interstitial nephritis

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

Acute dilatation of heart

(Duration) yrs. mos. ds.

(Signed) *W. S. Rublett*

M. D.

Aug 2/22 (Address) *2220 Garrison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Greenwood Cemetery

Aug 4, 1922

20 UNDERTAKER

ADDRESS

W. S. Rublett 2226 Fred St

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66525

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 249 Augusta Ave ST., 20 WARD)

2. FULL NAME Laura R Pickett

(a) RESIDENCE NO. 249 Augusta Ave ST., 20 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Pickett

6 DATE OF BIRTH (month, day, and year) Feb 3 - 1856

7 AGE 66 Years 6 Months — Days If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New York N.Y.

10 NAME OF FATHER Charles D Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia Pa

12 MAIDEN NAME OF MOTHER Elena M Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Dr Henry J Stahl
Augusta Frederick

15 AUG 3 - 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 19 21 to August 2, 19 22.

that I last saw her alive on August 2, 19 22

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY Arterio Sclerosis
(Secondary)

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? None

(Signed) Henry J Stahl, M. D.

(Address) 23 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Landon Park Cemetery

Aug 4 - 1922

UNDERTAKER

ADDRESS

F. B. Mappert 2206 Fred St

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rhs.

D 66526 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

327D 66526

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 3614 E Lombard ST., WARD) 26

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl S. Trans
(a) RESIDENCE NO. 3614 E Lombard ST., WARD

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26th 1900

7 AGE Years 21 Months 11 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Louis Trans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary E. Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mary E. Trans 3614 E Lombard St

15 Robert P. Harrison, Registrar

1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to July 30, 1922, that I last saw him alive on July 30, 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:
Tuberculous Meningitis

(duration) yrs. mos. ds. 7

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Bennett, M. D. 8.1.22 (Address) 2111 Hells

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer July 1922

20 UNDERTAKER Robert J. Turner Inc. 1442 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66527

113 D 66527

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3142 Stickleland St. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E Stewart

(a) RESIDENCE, No. 3142 Stickleland St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3 2 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

10 NAME OF FATHER George Stewart

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Rastka Young

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Rastka Young (Address) 3142 Stickleland St

15 Filed Robert D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10 1922, to Aug 3 1922, that I last saw him alive on Aug 2 1922, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH was as follows:

Acute Gastric - Enteric Intoxication

(duration) yrs. mos. ds. 25

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard W. Jones, M. D.

8-3-22 (Address) 2200 W. Lombard

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Augustine Cem. Elbridge Landing Md. Aug 5 1922

20 UNDERTAKER ADDRESS

John J. Field 2200 W. Lombard

St. Augustine Cem. Elbridge Landing Md.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 3 1922

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66528

66528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (Not *818 Whitelock St.* ST., *13* WARD)

2-FULL NAME

(a) RESIDENCE NO. *818 Whitelock St.*

(Usual place of abode)

Length of residence in city or town where death occurred *29* yrs. mos. ds.

How long in U. S., if of foreign birth? *27* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Amie Bercomit*

6 DATE OF BIRTH (month, day, and year) *April 10 1883*

7 AGE

Years *59*

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Clothing

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*

10 NAME OF FATHER *Moses Bercomit*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Amie Melchior*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14

Informant (Address) *Jack Lewis 1439 E. Balto St.*

15

Filed

AUG 4 - 1922

ROBERT H. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 3 1922*

17

I HEREBY CERTIFY, That I attended deceased from

June 25, 1922 to Aug. 3, 1922

that I last saw him alive on *Aug. 3, 1922*

and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. *one* mos. *8* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of *1*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Herman Seidel*, M. D.

19 (Address) *2404 E. Balto Pl*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Nehem Rosedale

DATE OF BURIAL

8/4 1922

20 UNDERTAKER

Jack Lewis 1439 E. Balto St.

ADDRESS

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 66529

D 66529

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 Calloway ST., 13 WARD)

2. FULL NAME

(a) RESIDENCE NO. 2215 Calloway ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds.WARD 13
(If non-resident give city or town and State)
How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Debusky6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Housewife

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

AUG 4 - 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 19 2217 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1922, to Aug 3, 1922, that I last saw him alive on Aug 2, 1922, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes, & chr. Intestinal
Nephritis(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Urinal
(Signed) Charles J. Blake, M. D.(Address) 1012 Breston St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Hehrensdorff
Jack Lewis & Calder

N. B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66530

CERTIFICATE OF DEATH.

44 D 66530

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

34 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

34 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

male

white

married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mary E Hetlich

6 DATE OF BIRTH (month, day, and year)

July 18 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

0

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

merchants & miners Trgn

(c) Name of employer

Boon Co. Ky

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Christian F. Hetlich

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

patient did not know

12 MAIDEN NAME OF MOTHER

Mary A. Keene

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown

14

Informant (Address)

Mary E Hetlich 900 Madison Ave

15

Filled

19

ROBERT R. KRAUTER

AUG 4 - 1922

Baltimore, Md.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 12, 1922, to Aug 3, 1922,

that I last saw him alive on 4.40 AM 7/3, 1922,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

carcinoma of esophagus over six months duration acute cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

hypostatic pneumonia

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical Picture

(Signed) J. H. Harrison, M. D.

(Address) Maryland Pen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

Aug 5th 1922

20 UNDERTAKER

ADDRESS

George Schilling & Sons

1126 E. Howard St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66531

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Albert S. Muth(a) RESIDENCE NO. 307 Sharp St. ST., 72 WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1856
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
66 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland10 NAME OF FATHER George Muth11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Maryland12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Baltimore,
(State or country) Maryland14 Informant Hospital Records,
(Address) Municipal Hospital.15 AUG 4 - 1922 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2 19 2217 I HEREBY CERTIFY, That I attended deceased from July 25, 19 22, to August 2, 19 22, that I last saw him alive on August 2, 19 22, and that death occurred, on the date stated above, at 10 A.M. am.
The CAUSE OF DEATH* was as follows:Acute thrombosisCONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Culture M. D.
(Signed) Clyde McNeil8/3/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Greenmount Cemetery Aug 6 19 22
20 UNDERTAKER Henry Lutz N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

66532

HEALTH DEPARTMENT—CITY OF BALTIMORE

66532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 32 St. Bond St ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Max Caplan

(a) RESIDENCE No. 32 St. Bond St ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds.

How long in U. S., if of foreign birth 34 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Helia Caplan

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

87

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Milk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER Solomon Caplan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER Untan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Leurs 1439 E. Balt. St

15

AUG 4 - 1922

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/22 19

17

I HEREBY CERTIFY, That I attended deceased from

7/28/22, 19, to 8/3/22, 19

that I last saw him alive on 8/3/22, 19

and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. Zimling M. D.

8/4, 1922 (Address)

1502 E. Balt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

MOVAL

Hehrer Mass Road

20 UNDERTAKER

Jack Leurs 1439 E. Balt. St

DATE OF BURIAL

8/4 1922

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66533

CERTIFICATE OF DEATH.

31

D 66533

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. WARD)

REGISTERED NO. 26
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Klumpp

(a) RESIDENCE NO. 3415 E. Fairmount ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years 60 Months 0 Days 0 If LESS than 1 day, hrs. 0 or min. 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Michael Klumpp

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Louisa Graft

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Hospital Records
(Address) M.T.H.

15 AUG 4 - 1922 ROBERT R. KRAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from AUG. 1, 1922, to AUG. 2, 1922,
that I last saw him alive on AUG. 2, 1922,
and that death occurred, on the date stated above, at 9.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 yrs. 0 mos. 0 ds.

CONTRIBUTORY
(Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum.

(Signed) Frederick J. P. M. D.

8-3-22. (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Not Cremel. DATE OF BURIAL July 4, 1922

20 UNDERTAKER Wm. Cook ADDRESS 505 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66534

CERTIFICATE OF DEATH.

179 D 66534

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Morrow Hosp* ST., *16* WARD)

2-FULL NAME

Robert Swann

(a) RESIDENCE NO. *Morrow Hosp* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *0* mos. *0* ds.

How long in U. S., if of foreign birth? *1* yrs. *0* mos. *0* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

Seafaring

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Mary Kilean

15

AUG 4 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8/3* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

6/5, 19*22*, to *8/3*, 19*22*.

that I last saw him alive on *8/3*, 19*22*.

and that death occurred, on the date stated above, at *9:30 A.M.*

The CAUSE OF DEATH* was as follows:

Chronic Salivular Heart Disease, Chronic Nephritis (Parenchymatous)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

General Septic Condition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Examination & Autopsy*

(Signed)

P. E. Schrevel M. D.

Aug 3, 1922 (Address) *Morrow Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

20 UNDERTAKER

S. Liverson & Son

DATE OF BURIAL

Aug 4 19*22*

ADDRESS *1127*

E. Balte

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE: (NO

2-FULL NAME

(Residence in Baltimore: No

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE
(State or country)

10 NAME OF
FATHER

11-BIRTHPLACE
OF FATHER
(State or country)

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

AUG 4 - 1922

Filed

191

Burial Permit Clerk.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE [For HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS]

At place
of death

Where was disease contracted,
if not at place of death?

Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66536

CERTIFICATE OF DEATH.

113 D 66536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Harford Ave. ST., 9 WARD)

2-FULL NAME Laura J. Brandt

(a) RESIDENCE NO. 1413 Harford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

11 mos. 10 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23 1921

7 AGE Years 11 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md.

10 NAME OF FATHER

John H. Brandt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Md.

12 MAIDEN NAME OF MOTHER

Elizabeth J. Brock

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Md.

14

Informant (Address)

Mr. John H. Brandt 1413 Harford Ave

15

AUG 4 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to Aug 3, 1922, that I last saw her alive on Aug 3, 1922, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

marasmus

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. P. Guernsey, M. D.

83, 1922 (Address) 1206 25th Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

20 UNDERTAKER

Henry Horck Lee

DATE OF BURIAL

Aug 5 1922

ADDRESS

1301 E. Eager St

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite: avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Intestinal Indigestion.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66537

CERTIFICATE OF DEATH.

44 D 66537

1-PLACE OF DEATH

St. Joseph's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Caroline & Hoffman STS.

WARD)

2-FULL NAME

John J. White

(a) RESIDENCE. NO.

Folston, Hartford Co. Md.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

28

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE

75

Years

Months

Days

If LESS than 1 day, hrs. or min.

about

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

087

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

b. E. Hornberger Benson, Md

15

Filed

AUG 4 - 1922

J. E. Kern

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 5, 1922, to Aug. 3, 1922, that I last saw him alive on Aug. 3, 1922.

and that death occurred, on the date stated above, at 6.30 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Carcinoma of pylorus (stomach)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. O'Donovan, M. D.

19 (Address) St. Jos. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Folston, Md Aug 4 1922

20 UNDERTAKER

ADDRESS

Wm J. Lickner Fox N x Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CCUPA-TION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1574-001* WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S. If of foreign birth?

20 yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 AUG 4 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 - 4 - 1922

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1922, to Aug 4 - 1922, that I last saw him alive on Aug 4, 1922, and that death occurred, on the date stated above, at 6 a. m. The CAUSE OF DEATH* was as follows:

Cardiac + Respiratory failure (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. Wallerstein, M. D.

, 19 (Address) 6 P Gettys

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOV.

20 UNDERTAKER

DATE OF BURIAL

8-4-1922

ADDRESS

Fact Lewis, 1439 E. Bate

D 66539

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66539

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 N. Fulton Ave ST.: 70 WARD)2-FULL NAME Mrs. Caroline M. Crothers(a) RESIDENCE. No. 2 N. Fulton Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos.ds. How long in U. S., if of foreign birth? 70 yrs. 10 mos. 9 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced Widowed
(or) WIFE of John L. Crothers6 DATE OF BIRTH (month, day, and year) July 22/18527 AGE Years 70 Months 0 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country) Philadelphia Pa.10 NAME OF FATHER William Bos11 BIRTHPLACE OF FATHER (city or town; State or country) Holland12 MAIDEN NAME OF MOTHER Joanna Baker13 BIRTHPLACE OF MOTHER (city or town; State or country) Holland.14 Informant Mrs B. Crothers
(Address) 2 N. Fulton Ave.15 Filed AUG 4 - 1922 ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2¹⁹ 2217 I HEREBY CERTIFY, That I attended deceased from August 1, 1921, to August 1, 1922, that I last saw her alive on August 1, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastases, stomach.(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical
(Signed) John B. Soun M. D.8-2, 1922 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL

London Park Cem. Aug. 5, 1922

20 UNDERTAKER

J. WALTER DAVIS,

FUNERAL DIRECTOR

ADDRESS

3307 Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

D 66540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No *Harford & Altona Ave* ST., *27* WARD)2-FULL NAME *Amelia Rittenhouse Green*(a) RESIDENCE NO *Harford & Altona Ave* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *11* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Dr. Morris B Green*6 DATE OF BIRTH (in month, day, and year) *Nov 13, 1888*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
33 8 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

- at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Kingorville*
(State or country) *md*10 NAME OF FATHER *Van Brant Rittenhouse*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Pa*12 MAIDEN NAME OF MOTHER *Laura V. Randle*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *md*14 *Dr. Morris B Green*
(Address) *Harford Rd - Altona Ave*15 *AUG 4 - 1922* ROBERT R. KRAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 1st 1922*17 I HEREBY CERTIFY, That I attended deceased from *May 4th*, 1922, to *Aug 1st*, 1922, that I last saw her alive on *Aug 1st*, 1922, and that death occurred, on the date stated above, at *4:15 P. m.*
The CAUSE OF DEATH* was as follows:*Miliary Tbr*(duration) *0* yrs. *6* mos. — ds.CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Shutun - X Ray*

(Signed)

Wilton L. Latham, M. D.49-*Purton St.*,
Aug 2, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park**Aug 4 1922*

20 UNDERTAKER

ADDRESS

John C. Mitchell 1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Secondary lung involvement
Started off without
any lung involvement
whatsoever. ←

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66541

CERTIFICATE OF DEATH.

113 D 66541
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S. Dallas ST., 3 WARD)

2-FULL NAME

Agnes Grubowski

(a) RESIDENCE NO.

410 S. Dallas

ST., 3 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 11 mos. 16 ds.

How long in U. S., if of foreign birth?

yrs. 11 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 18, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
11 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Md.

10 NAME OF FATHER

Stefan Grubowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore
Md.

12 MAIDEN NAME OF MOTHER

Helen Sopotynski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore
Md.

14

Informant (Address)

Stefan Grubowski
410 S. Dallas St.

15

AUG 4 - 1922

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from July 31, 1922 to Aug. 3, 1922, that I last saw her alive on Aug. 3, 1922 and that death occurred, on the date stated above, at 5:30 P.M. The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus Cem.

Aug 4, 1922

20 UNDERTAKER

ADDRESS

W. F. Sadowski

405 S. Ann St.

D 66542

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 66542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 N. Gilmor ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1215 N. Gilmor ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward Sterling

6 DATE OF BIRTH (month, day, and year) Dec. 1852

7 AGE Years 70 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Lewis H Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Sarah Royston

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

PARENTS

14 Informant

(Address)

Mrs Bennett

700 Madison Ave

15

Filed

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1922

17 I HEREBY CERTIFY, That I attended deceased from July 31 1922, to Aug. 2 1922, that I last saw her alive on Aug. 2 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 2, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem Aug 5 1922

20 UNDERTAKER

ADDRESS

Chas. E. Franck 802 Madison

1922

Burial Permit Clerk.

information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

66543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66543

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor* ST.: *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary-Ann Curran*(a) RESIDENCE. NO. *Preslon Valley St.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *1848*7 AGE Years *73* Months Days If LESS than 1 day, hrs. or min. *Unknown*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Michael Curran*11 BIRTHPLACE OF FATHER (city or town) *Ireland* (State or country)12 MAIDEN NAME OF MOTHER *Ann*13 BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or country)14 Informant *Little Sisters of the Poor* (Address) *Preslon Valley St.*15 *Robert P. Harrison*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 4* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *no record* 19 to 19that I last saw her alive on *July 30* 19*22*and that death occurred, on the date stated above, at *5 a.m.*

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY *Atherosclerosis* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. R. Warner*, M. D.14, 1922 (Address) *1133 Valley St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Vincent's**Aug. 5* 19*22*

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Greenmount Ave.

INFORMATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG 4-1922

MORE ✓ 001
74 D 66544

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME Albert Freidel

(Usual place of abode) 72 yrs. 7 mos. 15 ds. (If non-resident give city or town and State)
 Length of residence in city or town where death occurred 72 yrs. 7 mos. 15 ds. How long in U. S., if of foreign birth? 72 yrs. 7 mos. 15 ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/2 1922

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1932, to Aug 7, 1932, that I last saw him alive on Aug 7, 1932, and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis of Throat

(duration) 5 mos. 7 ds.

CONTRIBUTORY (Secondary) 1/11/1944

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic examination of stool

(Signed) Christopher D. Galt, M. D.

Address) 1437 E. 1st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19/PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL
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20 UNDERTAKER	ADDRESS
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Philip Morris Sales

UG 4-1922

National Forest Glor

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS,
BY PHYSICIAN.

*Senility. Cerebral
hemorrhage. Apoplexy*

CG 4-1922

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66545 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 621 N. Glover St. Ward 7) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME: Frank Rocks
(Residence in Baltimore: No. 621 N. Glover St.; yrs. 56 - 7 - 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male
4-COLOR OR RACE: White
5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed
6-DATE OF BIRTH: Dec 24 1865
(Month) (Day) (Year)
7-AGE: 56 yrs. 7 mos. 11 ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Produce Dealer
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), City
10-NAME OF FATHER: John Rocks
11-BIRTHPLACE OF FATHER, (State or Country), Md
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose C. Hynan
(Address) 621 N. Glover

15. Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug 3 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Mr. Garrison
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. B. Brame M. D.
(Coroner)
(Address) 312 B. Brame

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

McBarnel Aug 4 1922

20-UNDERTAKER, ADDRESS

Philip Henry Orleans St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66546

CERTIFICATE OF DEATH.

164 D 66546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Warner St. W. 11th St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samia Harrison(Residence in Baltimore: No. 14 Warner St. W. 11th St.) 30 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. 2 4-COLOR OR RACE, C. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow6-DATE OF BIRTH, unknown (Month) (Day) 1 (Year) 7-AGE, 35 yrs., mos., ds. If LESS than 1 day, hrs. or min.8-OCCUPATION: (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) none9-BIRTHPLACE, (State or Country), Ind10-NAME OF FATHER, unknown11-BIRTHPLACE OF FATHER (State or Country), Ind12-MAIDEN NAME OF MOTHER unknown13-BIRTHPLACE OF MOTHER (State or Country), Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A. Harrison(Address) 1203 3rd St. N. W.

15-

Filed Robert M. Harrison

Registrar.

4-1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 2, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 1 1922 to Aug 1 1922, that I saw him alive on Aug 1 1922, and that death occurred, on the date stated above, at 8:30 p. m. The CAUSE OF DEATH* was as follows: unknown medical condition(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.(Signed) J. A. Harrison M. D., 191... (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Glendall, Prince George Co. Aug 4, 192220-UNDERTAKER ADDRESS 1203 3rd St. N. W.James A. Harrison

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.: 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Kirby(a) RESIDENCE. NO. UnknownST. 26 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18557 AGE Years Months Days If LESS than 1 day, hrs. or min. 67 -- -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Presser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records, (Address) Municipal Hospital.15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3 19 2217 I HEREBY CERTIFY, That I attended deceased from February 23 19 22, to August 3 19 22, that I last saw her alive on August 2 19 22, and that death occurred, on the date stated above, at 6:10 A.M. The CAUSE OF DEATH* was as follows:Chronic myocarditisCONTRIBUTORY Myocardial insufficiency (duration) yrs. mos. ds. (Secondary) (duration) yrs. mos. ds. 77

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clifford M. Hall M. D.8/3/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park CemAug 5 19 22

20 UNDERTAKER

ADDRESS

Mr. & Mrs. J. W. Trefel & Son 801 N. Fayette

G 4-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE D 66549

D 66549

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 S Ann Street ST., 2 WARD)2-FULL NAME Czeslawa Markowska(a) RESIDENCE No. 233 S Ann Street ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov 10 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	8		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Theodore Markowski
Poland11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER Helen Lubinski13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant Theodore Markowski
(Address) 233 S Ann Street15 Filed Robert P. Harrison,
19 1922

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1922

17

I HEREBY CERTIFY, That I attended deceased from
Aug 1 - 1922 to Aug 4 1922that I last saw him live on Aug 3, 1922and that death occurred, on the date stated above, at 6:10 A. M.

The CAUSE OF DEATH* was as follows:

Enteric Colitis(duration) yrs. mos. 8 ds.CONTRIBUTORY (Secondary) Enteric Colitis(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. R. Jones M. D.
Aug 4, 1922 (Address) 801 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy RosaryAug 5 1922

20 UNDERTAKER

ADDRESS

John M. Weber1803 Bank St.

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66550 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 509 So. Collington Ave St. 107 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Yeager

(Residence in Baltimore: No. 509 So. Collington Ave 40 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, Married (Write the word.)

6-DATE OF BIRTH, Unknown 1 (Month) (Day) (Year)

7-AGE, about 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Worked in Packing House (b) General nature of industry, business, or establishment in which employed (or employer), Frisco, 086

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Frank Yeager

(Address), 509 So. Collington Ave

15 Robert P. Harrison, Registrar.

Filed 1922 4-1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3rd 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Lungs - at once (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Wm. B. Horton M. D. Aug 3rd 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holt Rosary August 5, 1922

20-UNDERTAKER, ADDRESS

John S. Weber 1803 Bank

*Not tuberculous Cause of hemorrhage
unknown*

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyemia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicemia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66551

CERTIFICATE OF DEATH.

44 D 66551

1-PLACE OF DEATH

CITY OF BALTIMORE: (N) 303 Wyman Ave 17 WARD)

2-FULL NAME

Arlin E Beebe

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

303 Wyman Ave

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Sophia Beebe

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 25 1868

7 AGE

Years

Months

Days

If LESS than

1 day, hrs

or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sheet Metal

(b) General nature of industry, business, or establishment in which employed (or employer)

Worker

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Ohio

10 NAME OF FATHER

John E Beebe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Anna Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ohio

14

Informant (Address)

Sophia Beebe 303 Wyman Ave

4-1922

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 3 1922

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 22 1922, to August 2 1922.

that I last saw him alive on August 2 1922,

and that death occurred, on the date stated above, at 2 15 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach,

(duration) ? yrs. 7 mos. ? ds.

CONTRIBUTORY (Secondary)

Exhaustion

(duration) 1 yrs. 4 mos. 1 ds.

18 Where was disease contracted if not at place of death?

?

Did an operation precede death? yes Date of Feb, 1922

Was there an autopsy? no

What test confirmed diagnosis? X-Ray and Operation

(Signed) William G. Hopton, M. D.

, 19 (Address) 2919 Huntington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cemetery Aug 5 1922

20 UNDERTAKER

ADDRESS

William Beck 5026 North Ave

D 66552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66552

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Penrose Ave

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 2008 Penrose Ave

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Bradford J Brinkley

6 DATE OF BIRTH (month, day, and year)

Dec 5 1884

7 AGE

Years

Months

Days

37

37

7

29

If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Brooklyn N.Y.

10 NAME OF FATHER

Jos. A. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

John Robin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant

(Address)

2008 Penrose Ave.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3rd 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 3rd 1922 to Aug 3rd 1922

that I last saw him alive on Aug 3rd 1922

and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Hemiplegia
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ray B. Wilson, M. D.

805, 1922 Address 400 N. Rayson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cmt.

8.5 - 1922

20 UNDERTAKER

ADDRESS

William Cook.

502 C. North

AUG 4-1922

Burial Permit Clerk

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66553

CERTIFICATE OF DEATH.

D 66553

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Evergreen Pl., ST. WARD) ²⁷

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Gordon B. Constable

(a) RESIDENCE. NO.

6 Evergreen Pl., ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March - 28 - 1908

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1446

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti Md

10 NAME OF FATHER

Chas B Constable

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balti Md

12 MAIDEN NAME OF MOTHER

Libbiana Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balti Md

14

Informant (Address)

Gordon B Constable
6 Evergreen Place

15

Date

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov, 1921, to Aug 3, 1922that I last saw him alive on Aug 3, 1922and that death occurred, on the date stated above, at 7:00 P. m.

The CAUSE OF DEATH* was as follows:

Osteo-Sarcoma of R. Femur.(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Brooklyn N.Y.Did an operation precede death? Yes Date of Sept 1921Was there an autopsy? noWhat test confirmed diagnosis? Lab. & X-ray(Signed) Geo W. W. Hoff, M. D.8/4, 1922 Address 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Parkwood CemAug 5 1922

20 UNDERTAKER

ADDRESS

William Cook2020 N. Charles

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG 4

1922

Robert P. Harrison,

Registrar

Burial Permit Granted

(Rohr)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66554

CERTIFICATE OF DEATH.

49 D 66554

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831

ST., 9 WARD)

2-FULL NAME

Minnie Rohr

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1831 Arguilla

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

Now long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Kernan F. Rohr

6 DATE OF BIRTH (month, day, and year)

Jan 29 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

6

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

831

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

George Rohr

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katherine Rohr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Kernan F. Rohr

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

May 4 1922, to Aug 3 1922,

that I last saw her alive on Aug 3 1922,

and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder and Intestines

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of May 24 1922

Was there an autopsy? No

What test confirmed diagnosis? Exam. of bladder

(Signed) Geo. J. Sargent M. D.

(Address) 1107 Kensington Bld

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

20 UNDERTAKER

H. M. Cook

DATE OF BURIAL

Aug 15 1922

ADDRESS

445 N. E.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 4

1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66555

D 66555

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hospital* ST. *5* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Emma Franklin*(a) RESIDENCE. NO. *4500 Reisterstown Road* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Moses Franklin*6 DATE OF BIRTH (month, day, and year) *May 11, 1869*7 AGE Years *53* Months *2* Days *24* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Samuel Venline*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Bavaria*12 MAIDEN NAME OF MOTHER *Caroline Meyer*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Bavaria*14 Informant *Hosp. Record* (Address)15 Filed *Robert P. Harrison,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 4* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *July 27*, 19*22*, to *August 4*, 19*22*, that I last saw him alive on *August 4*, 19*22*, and that death occurred, on the date stated above, at *5:20 P.M.*

The CAUSE OF DEATH* was as follows:

*Diabetes mellitus -
diabetic gangrene toes, etc.*(duration) *4* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *7-28-22*Was there an autopsy? *No*What test confirmed diagnosis? *Uringlysis*(Signed) *Gordon A. Seagrave* M. D.8-4-19 (Address) *Union Memorial Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

David Sandheim *118-20, 1922*

20 UNDERTAKER

Hebrew Friendship Cem. *8/6/22*

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

4-1922 Burial Permit Clerk.

66556
D 66556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 Hilleu St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Mohan

(Residence in Baltimore: No. 1105 Hilleu St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH Sept 1858 (Month) (Day) (Year)

7-AGE 63 yrs. mos. ds. If LESS than 1 day hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Labour (b) General nature of industry, business, or establishment in which employed (or employer) 04

9-BIRTHPLACE (State or Country) Ireland

PARENTS: 10-NAME OF FATHER John Mohan 11-BIRTHPLACE OF FATHER (State or Country) Ireland 12-MAIDEN NAME OF MOTHER John Mohan 13-BIRTHPLACE OF MOTHER (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mohan (Address) 527 W. Franklin

15- Robert P. Harrison, Registrar. Filed 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug-14 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema

(Duration) yrs. mos. ds.

(Signed) J. G. Moran M. D. (Coroner)

102 (Address) 3000 E. Baltimore

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Newbatholpen 8/51 1922

20-UNDERTAKER ADDRESS 3000 E. Baltimore

J. G. Moran E. Baettr

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

65

D 66557 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66557

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 N Carey ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harry Lesseno

(a) RESIDENCE NO.

1310 N Carey

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Lucy Lesseno

6 DATE OF BIRTH (month, day, and year)

Not known

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

West Indies Island

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant (Address)

William Henry Lesseno 1019 N Carrollton Ave

15

FUGED

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 3 1922

I HEREBY CERTIFY, That I attended deceased from

July 31, 1922, to Aug 3, 1922,

that I last saw him alive on Aug 3, 1922,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Fry, M. D.

8/4, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 MANNER OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Not known

Aug 5 1922

20 UNDERTAKER

ADDRESS

Sam. H. Base Dow 1400 Mosher

Burial Permit Clerk.

N. B. WRITE FULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66558

CERTIFICATE OF DEATH.

D 66558

1. PLACE OF DEATH

CITY OF BALTIMORE, (No. *St. Joseph's Hospital* ST., *9* WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs. — mos. — ds.How long in U. S., if of foreign birth? *Life* yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 7, 1847

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or — min.

74 11 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Religious Nun**Order of St. Francis*

9 BIRTHPLACE (city or town) (State or country)

York Pa.

10 NAME OF FATHER

John Heiman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Hutzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Records of St. Joseph's Hosp

15

Filed

, 19

1922

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 3, 1922, to Aug 3, 1922,

that I last saw her alive on

*Aug 3, 1922,*and that death occurred, on the date stated above, at *10:15* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Probably Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Unknown

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

J. H. Schurich M. D.

, 19

(Address)

St. Joseph's Hospital

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery**Aug 7 1922*

20 UNDERTAKER

ADDRESS

*Henry Hoeck, Son**1301 E. Eager St*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66560

CERTIFICATE OF DEATH.

31 D 66560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 239 S. Third ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Paul

(a) RESIDENCE NO.

239 S. Third

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced

HUSBAND of Irene B. Paul
WIFE of6 DATE OF BIRTH (month, day, and year) July 1 - 1890

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.3212

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman 866

(h) General nature of industry, business, or establishment in which employed (or employer)

Wholesale Produce

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md.10 NAME OF FATHER John H. Paul11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) md.12 MAIDEN NAME OF MOTHER Bora Meek13 BIRTHPLACE OF MOTHER (city or town) Annapolis, Md.
(State or country) Md.

14

Informant Irene B. Paul(Address) 239 S. Third St.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

1 Aug, 1922, to 3 Aug, 1922.that I last saw him alive on 3 Aug, 1922.and that death occurred, on the date stated above, at 11:55 A. m.The CAUSE OF DEATH was as follows: Had been ill 2 years agofor some condition.AcuteSubacute (duration) yrs. mos. ds.CONT Chronic parenchymatous

(Secondary) (duration) yrs. mos. ds.

nephritis

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. + Mohr M. D.8/4, 1922 (Address) 3015 Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Howard's Cemetery, Stemmer RunDATE OF BURIAL Aug 6 1922

20 UNDERTAKER

Zirkler + ZirklerADDRESS 1739 E. Eager

PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922

Burial Permit Clerk

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS

BY PHYSICIAN.

*Positive sputum
examination 2 yrs.
ago at Health Dept.
Pulmonary Tuberculosis*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 Thacker St., 90 Ward)

Registered No. C.

2-FULL NAME

(Residence in Baltimore: No. 1105 Thacker St., yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Caucasian* 5-Single, Married, Widowed, or Divorced, *Married*

6-DATE OF BIRTH, *Unknown*

7-AGE, *about 65*

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Unknown*
(b) General nature of industry, business, or establishment in which employed (or employer), *040*

9-BIRTHPLACE, (State or Country), *Maryland*

PARENTS.

10-NAME OF FATHER, *Chas Gibson*

11-BIRTHPLACE OF FATHER, (State or Country), *Md.*

12-MAIDEN NAME OF MOTHER, *Samuel Brodgon*

13-BIRTHPLACE OF MOTHER, (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Carroll Gibson*

(Address), *Dorsey Md.*

15-

Filed

Robert P. Harrison,

5-1922

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 4 22*

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Endocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Robert P. Harrison* M. D. (Coroner.)

1922 (Address) *115 E West St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Gravestone*

DATE OF BURIAL, *8-6-22*

20-UNDERTAKER, *Er B Harle*

ADDRESS

115 E West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66562

D 66562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Miner's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

Green + Lombard

ST.

WARD

2-FULL NAME

George Remmer (REMMER)

(a) RESIDENCE. NO.

2359 Frederick

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 11, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

XX

2

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Joseph Remmer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Berrie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Mother, Berrie Jones

15

Filed

Robert P. Harrison

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to Aug 5, 1922, that I last saw him alive on Aug 4, 1922, and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion (duration) yrs. 2 mos. 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John D. Bebery M. D.

19 (Address) 1629 St Paul St Baltimore Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cemetery

20 UNDERTAKER

ADDRESS

H. P. Support 2256 Frederick Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 5

HEALTH DEPARTMENT—CITY OF BALTIMORE

66563

CERTIFICATE OF DEATH.

REGISTERED NO.

66563

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

col.

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mr. Jones

6 DATE OF BIRTH (month, day, and year)

March 12, 1874

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

48

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Balt.

10 NAME OF FATHER

James R. Demby

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Annie Ringold

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant

Mrs. Alice Moore

(Address)

1435 Argyle Ave.

15

Filed

Robert P. [unclear] 18**

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 29, 1922, to Aug 3, 1922,

that I last saw him alive on Aug 3, 1922,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Baltimore

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. R. Boykin, M. D.

. 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int. Auburn Cem Aug 6, 1922

20 UNDERTAKER

ADDRESS

Wm. G. Locke 1302 Jefferson

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG 5

1922 Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 66564

D 66564

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Womans Hospital* ST. *14* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Womans Hosp.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-SINGLE, MARRIED, *Single* WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

July 23, 1922, 1922
(Month) (Day) (Year)

7-AGE,

..... yrs. mos. *15* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer), *None*

9-BIRTHPLACE, (State or Country),

Balto. Md.

10-NAME OF FATHER,

Daniel Gilson

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md.

12-MAIDEN NAME OF MOTHER

Sally Huteritz

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Hosp. Record*

(Address)

15-

Filed *Robert P. Harrison,* 1922 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 4, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 21, 1922, to *Aug 4, 1922*,
that I saw him alive on *Aug 4, 1922*.

and that death occurred, on the date stated above, at *9:55 p.m.*

The CAUSE OF DEATH* was as follows:

Buhl's Disease

.....

.....

..... (Duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *D. Gilson* M. D.*Aug 5, 1922* (Address) *Womans Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Har Sinai Cem. DATE OF BURIAL, *8/6/22*

20-UNDERTAKER

David Erdheim ADDRESS *113 W. 7th**Royal Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66565

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 136 1/2 H. Street)

St. 11

Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 136 1/2 H. Street)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE, 45

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Book
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

5-1922

Robert P. Harrison,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 7, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Cheliosis (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) M. D. (Address) 102 1/2 3rd St. Bk. 11

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Charles Ave. Aug 6, 1922

20-UNDERTAKER,

ADDRESS

David L. Carter 916 Penn. Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66566

HEALTH DEPARTMENT—CITY OF BALTIMORE D 66566

CERTIFICATE OF DEATH.

132

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. *1019 Pennsylvania* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *35* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 21 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

3

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Edw. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Jane Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Robert P. Harrison

15

1822

Robert P. Harrison, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 4 19 22*

17

I HEREBY CERTIFY, That I attended deceased from *May 29, 19 22* to *Aug 4 19 22* that I last saw him alive on *Aug 4 19 22* and that death occurred, on the date stated above, at *3 45 a.m.* The CAUSE OF DEATH* was as follows:

Stricture of Urethra & Bladder Calculus

(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uremia

(duration) *2* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes (2) Date of 6/24/22 - 7/21/22*

Was there an autopsy? *No*

What test confirmed diagnosis? *Operative*

(Signed)

Dr. J. S. Harrison M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Ambrose Aug 6 19 22

20 UNDERTAKER

Daniel E. Smith

UG 5

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66567

CERTIFICATE OF DEATH.

113 D 66567
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 M. Burr ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Barker

(a) RESIDENCE. No. 107 M. Burr ST. 22 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 10 mos.

ds. How long in U. S., if of foreign birth?

yrs. 10 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 29-1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
10 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Henry Barker

11 BIRTHPLACE OF FATHER (city or town) Perm (State or country)

12 MAIDEN NAME OF MOTHER Emma Barker

13 BIRTHPLACE OF MOTHER (city or town) Perm (State or country)

14 Informant Henry Barker (Address) 107 M. Burr St.

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1922, to Aug 4, 1922

that I last saw him alive on Aug 4, 1922 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Enterobacter

(duration) yrs. mos. 5 ds.

CONTRIBUTORY Cause of death (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Harrison, M. D.

Aug 4, 1922 (Address) 502 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

Aug 7 1922

20 UNDERTAKER

Wm. Leach

ADDRESS

502 E. North Ave.

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

65-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE 66568

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2023 Longwood ST., 15 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

70 yrs. 8 mos. 27 ds.

How long in U. S., if of foreign birth?

70 yrs. 8 mos. 27 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Ann Elizabeth Kirkman

6 DATE OF BIRTH (month, day, and year)

Nov 7, 1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

8

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Painting

self

9 BIRTHPLACE (city or town)

(State or country)

Baltimore

10 NAME OF FATHER

Daniel Steffy

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14 Informant

(Address)

Mr. John H. Steffy (Son)

2023 Longwood St.

15

AUG 5 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 3rd 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 26, 1922, to Aug 3, 1922,

that I last saw him alive on Aug 3, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Inguinal Hernia (Strangulated)

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY Intestinal obstruction

(Secondary) Acute

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Lee H. Coolahan, M. D.

(Address) 24 N. Thelton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

20 UNDERTAKER

MOWEN COMPANY

100 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66569

CERTIFICATE OF DEATH.

87 D 66569

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2645 Penna Ave ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 2645 Penna Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ✓ mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofFrances Ann Stone6 DATE OF BIRTH (month, day, and year) Mar 21-18567 AGE 66 Years 3 Months 14 Days If LESS than 1 day ✓ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cement work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Charles County Md

10 NAME OF FATHER

Jos. Stone

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Charles County Md

12 MAIDEN NAME OF MOTHER

Maria Farrell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Charles County Md

14

Informant

(Address)

Charles A. Stone2645 Penna Ave

15

Filed

19

AUG 5-1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 19 2217 I HEREBY CERTIFY, That I attended deceased from July 20, 19 22, to Aug 4, 19 22,that I last saw him alive on Aug 3, 19 22,and that death occurred, on the date stated above, at 9.45a. m.

The CAUSE OF DEATH* was as follows:

Pericarditis(duration) ✓ yrs. 7 mos. ✓ ds.

CONTRIBUTORY (Secondary)

Nephritis Acute(duration) ✓ yrs. 2 mos. ✓ ds.

18 Where was disease contracted if not at place of death?

Not knownDid an operation precede death? toDate of ✓Was there an autopsy? toWhat test confirmed diagnosis? usual(Signed) George C. Shannon, M. D.Address 744. 19 22 700 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery Aug 7 19 22

20 UNDERTAKER

ADDRESS 19 22Harry W. Ehlen W. Nord a

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66570

D 66570

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 5 WARD)2-FULL NAME Thomas White(a) RESIDENCE NO. 316 Spring st.

(Usual place of abode)

ST. 5 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18977 AGE Years 25 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER White11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Rosie Walbrey13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant Hospital Records (Address) M.T.H.15 Robert P. Harrison, 19 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 192217 I HEREBY CERTIFY, That I attended deceased from March 17, 1922 to Aug. 1, 1922 that I last saw him alive on Aug. 1, 1922and that death occurred, on the date stated above, at 4.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 1 yrs. mos. ds.CONTRIBUTORY Tuberculous osteitis of spine (Secondary) (duration) 7 yrs. mos. ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sp. in sputum, X-ray(Signed) Francis L. Dodge M. D.8-2-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

AUG 1 19 1922

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 66571

PLACE OF DEATH

90 D 66571

REGISTERED NO. C

CITY OF BALTIMORE (No. 1148 Hull St.)

FULL NAME James Herbert

(Residence in Baltimore: No. 1148 Hull St.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH Nov. 16, 1864 (Month) (Day) (Year)

7-AGE 57 yrs. 8 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Watchman (b) General nature of industry, business, or establishment in which employed (or employer) Carpenter Shop

9 BIRTHPLACE (State or country) Ireland

10-NAME OF FATHER John Herbert

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Barrett

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary Beale

(Address)

1423 Beason St.

15.

Robert P. Harrison,

191

1922

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 2, 1912 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1, 1912, to Aug. 2, 1912, that I saw him alive on Aug. 2, 1912, and that death occurred, on the date stated above, at 6:10 P. M. The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY) Acute Dilatation of Heart (Duration) yrs. mos. 1 ds. (Signed) Thos. F. Stevens M. D. 8/3, 1912 (Address) 2878 Harford Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted? If not at place of death? Former or usual residence?

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20-UNDERTAKER ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

165 D 66572

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital, Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Anna C. Thomas.

(Residence in Baltimore: No. 1621 Olive St., St.; yrs., 30 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Married (Write the word.)

6-DATE OF BIRTH, July 12th, 1892. (Month) (Day) (Year)

7-AGE, 30 yrs., 0 mos., 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, John Ezeay.

11-BIRTHPLACE OF FATHER, (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Mary Larimore.

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael J. Thomas. (husband)

(Address) 1621 Olive St.

15- Robert P. Harrison,

1922 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1st, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride of Mercury poisoning. Suicide. OMR

(Duration) yrs. mos. ds.

CONTRIBUTORY, Acute Uraemia. (Secondary)

(Duration) yrs. mos. ds. (Signed) Otto H. Reinhard, M.D.

(Coroner) Aug 2nd 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? 1621 Olive St. July 26th, 1922.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Graveside 8/5 1922

20-EXEMPTATION, ADDRESS,

384

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

66573

HEALTH DEPARTMENT--CITY OF BALTIMORE

66573

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *22* Ward)

2-FULL NAME *Vincent Scubte (Scrito)*

(Residence in Baltimore: No. *534 W. Conway St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE *White*

5-Single, Married, Widowed, or Divorced. *Single*

6-DATE OF BIRTH. 1915 (Month) (Day) (Year)

7-AGE *7* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Dom.*
(b) General nature of industry, business, or establishment in which employed (or employer) *Dom.*

9-BIRTHPLACE, (State or Country). *Balt. Md.*

PARENTS.

10-NAME OF FATHER. *Vincent Scubte*

11-BIRTHPLACE OF FATHER. (State or Country). *Italy*

12-MAIDEN NAME OF MOTHER. *Anna Lazebno*

13-BIRTHPLACE OF MOTHER. (State or Country). *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Vincent Scubte*
(Address) *5-34 W Conway St.*

15-*Robert T. Harrison,*
Filed *1922* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Aug 4* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* ~~inquest~~ *inquiry* thereon and from the evidence obtained by said *inquest* ~~inquest~~ *inquiry* and that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Joalmed skull + shock
a few hours
CONTRIBUTORY *Struck by Auto*
(Signed) *H. H. Gorman* M. D. (Coroner)
8-5 1922 (Address) *117 W. Saratoga St.*
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL. *St. Mary's* DATE OF BURIAL. *8/5* 1922
20-ADDRESS *1318 R. 1st St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66574

D 66574

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Fairmount Ave ST.; 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Stallings(a) RESIDENCE: NO. 1520 Fairmount Ave WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20, 1955

7 AGE

68

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14

Informant (Address) 1520 Fairmount Ave

15

Filed Robert P. Harrison 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 19 22

17

HEREBY CERTIFY, That I attended deceased from

Feb 1, 19 22, to Aug 4, 19 22that I last saw h./m. alive on Aug 4, 19 22and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
Larynx(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Harrison, M. D., 19 (Address) 3100 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore CemeteryAug 7, 1922

20 UNDERTAKER

ADDRESS 1442Robert L. Turner Inc4 Broadway

5-1922 Burial Permit Clerk

66575 HEALTH DEPARTMENT—CITY OF BALTIMORE

66575

D 66575

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 31 1915

7 AGE

7

Years

4

Months

6

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

AUG 6 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 5

1922

17

I HEREBY CERTIFY, That I attended, deceased from

August 1

19

22

to

August 5

19

22

that I last saw her alive on

August 5

19

22

and that death occurred, on the date stated above, at

5:40 A. M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration)

yrs.

mos.

12

ds.

CONTRIBUTORY (Secondary)

Acute Peritonitis

(duration)

yrs.

mos.

10

ds.

18 Where was disease contracted

if not at place of death?

At home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinically

(Signed)

James Hubert McPherson, M. D.

19

(Address)

Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Randy Mt. Carroll Co Aug 7 1922

20 UNDERTAKER

ADDRESS

J. H. B. Ankerd & Son Westminster

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 15-7586 66576)

JOHNS HOPKINS HOSPITAL

WARD 7

2. FULL NAME

Virginia Carver

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Parkville Md.

WARD

(If non-resident give city or town and State)

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 2-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

James Carver

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Nattie Ship

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant: JOHNS HOPKINS HOSPITAL (Address)

15

Filed AUG 6-1922

ROBERT R. KRAUTER,

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

0066576
161 D 66576

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 4 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 3rd, 1922, to Aug 4, 1922,

that I last saw him alive on Aug 4, 1922,

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles B. Mason, M. D.

85, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Carroll Chapel Cemetery

Aug. 6 1922

20 UNDERTAKER

ADDRESS

Fred L. Lawrence

Baltimore

66577
D 66577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1837. N Washington ST. WARD 8

2-FULL NAME Anna L. Ratt.

(a) RESIDENCE. No. 1837 N. Washington ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Rott

6 DATE OF BIRTH (month, day, and year) Oct 28-1868

7 AGE Years 53 Months 10 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

10 NAME OF FATHER Frederick Erdman

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant George S. Holman (Address) 1837 N. Washington St

15 Filed . 19 ROBERT K. KRAUTER Registrar

AUG 6-1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1922

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1922, to Aug 5, 1922,

that I last saw her alive on Aug 4, 1922,

and that death occurred, on the date stated above, at 12:35 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Diagnosis

(Signed) Adolph C. Eisenberg, M. D.

15, 1922 (Address) 2201-2203 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Parkwood Cemetery

Aug 8 1922

20 UNDERTAKER

ADDRESS

Frank Lusschm Sons

Fullerton

66578 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

24 Woodlea Terrace

REGISTERED NO.

66578

CITY OF BALTIMORE: (No. 24 Woodlea Terrace)

ST. 27

WARD

2-FULL NAME

Konrad E. Ripberger

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

24 Woodlea Terrace Gardenville

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

55 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mary E. Ripberger

6 DATE OF BIRTH (month, day, and year)

Oct 30 1847

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or min.

74

9

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Arundel Sandbar

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

Unknown

14

Informant (Address)

Mary E. Ripberger Gardenville Md

15

File AUG 6 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1916 to Aug 4 1922 that I last saw him live on Aug 3 1922 and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Central Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Heller M. D.

1922 Address 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

BALTIMORE CEMETERY Aug 7 1922

20 UNDERTAKER

ADDRESS

Fred Lassmanns Fullerton

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

966579 HEALTH DEPARTMENT—CITY OF BALTIMORE 966579
46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2033 Keyser ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No. 2033 Keyser ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

David Ball

6 DATE OF BIRTH (month, day, and year)

1868
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
54 - -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

AUG 15 1922

ROBERT R. KRAUTER, Registrar

Daniel Peralt Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 19, 1922, to Aug. 13, 1922.

that I last saw her alive on Aug. 13, 1922,

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Robinson, M. D.

19 (Address) 1508 Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

1908 Auburn Ave Aug 14 1922

20 UNDERTAKER

ADDRESS 11407

Brown & Thelander, Schermer

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66580

CERTIFICATE OF DEATH.

113 D 66580

PLACE OF DEATH

CITY OF BALTIMORE (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH

June 18, 1922
(Month) (Day) (Year)

7-AGE

1 yr., 12 mos., 12 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

none

9-BIRTHPLACE, (State or Country).

Brooklyn Md

10-NAME OF FATHER

George E Hardy

11-BIRTHPLACE OF FATHER (State or Country).

D.C.

12-MAIDEN NAME OF MOTHER

Maggie Green

13-BIRTHPLACE OF MOTHER (State or Country).

Brooklyn Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George E Hardy

(Address)

102 Carroll St Brooklyn Md

15-

AUG 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 4, 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Eulenia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. S. H. Baker M. D.
(Coroner.)
8-5 1912 (Address) 508 E. Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Furnace Branch

DATE OF BURIAL

August 6, 1922

20-UNDERTAKER

John H. Deany

ADDRESS

715 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66581

CERTIFICATE OF DEATH.

90 D 66581F
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital

ST.

WARD) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Mary Milner

(a) RESIDENCE. No.

1261 E. Fayette

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

10

yrs.

mos.

ds.

How long in U. S., If of foreign birth?

10

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)
Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Autumn

7 AGE

33

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

137

(c) Name of employer

9 BIRTHPLACE (city or town).
(State or country)

Russia

10 NAME OF FATHER

Wolf Neuman

PARENTS

11 BIRTHPLACE OF FATHER (city or town).
(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Ray

13 BIRTHPLACE OF MOTHER (city or town).
(State or country)

Russia

14

Informant

(Address)

H. Milner
1261 E Fayette St

15

AUG 6 - 1922

ROBERT R. KRAUTER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 21, 1922, to August 4, 1922,

that I last saw her alive on August 4, 1922,

and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure due
to Coronary Emboles.

1 hour

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

Subacute Bacterial Endocarditis

(duration)

yrs.

mo(?)

ds.

18 Where was disease contracted

?

if not at place of death?

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Blood culture

(Signed)

Moses Tellman

, M. D.

Aug 4 1922

(Address)

Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Mt Carmel

DATE OF BURIAL

Aug 6 1922

20 UNDERTAKER

J. Linn on Balto St

ADDRESS

1127 E

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 66582

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 25 ST. 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 6 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 AUG 6 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8-5-1922

17

I HEREBY CERTIFY, That I attended deceased from 4-12-1922, to 8-5-1922,

that I last saw him alive on 8-5-1922

and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66583

CERTIFICATE OF DEATH.

Registered No. C 66583

1-PLACE OF DEATH

City of BALTIMORE: (No. *1630 Appleton* St. *15* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1630 Appleton* St.; yrs. *32* mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married*
(Write the word.)

6-DATE OF BIRTH, *Aug - 3 - 1890*
(Month) (Day) (Year)

7-AGE, *51* yrs. *3* mos. *3* ds. If LESS than 1 day, *hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Traveling Club*
(b) General nature of industry, business, or establishment in which employed (or employer), *Dalson*

9-BIRTHPLACE, (State or Country), *Russia*

10-NAME OF FATHER, *Symon Simpson*

11-BIRTHPLACE OF FATHER, (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER, *Nettie -*

13-BIRTHPLACE OF MOTHER, (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *J. Lewis*

(Address), *1439 E. Balto St.*

15-AUG 6 - 1922

192 ROBERT R. KRAUTER,

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug - 5 - 1922*
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*, (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said *inquest*, (Inquest, autopsy or inquiry.)
and that said deceased came to *his* death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Myocardial Infarction
(Duration) *3* yrs. *3* mos. *3* ds.

CONTRIBUTORY (Secondary)

(Duration) *3* yrs. *3* mos. *3* ds.

(Signed), *J. Lewis* M. D.
(Coroner.)

18- (Address) *1439 E. Balto St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, *3* yrs. *3* mos. *3* ds. In the State, *3* yrs. *3* mos. *3* ds.

Where was disease contracted. If not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. John's Cemetery *8-6-* 19 *22*

20-UNDERTAKER, ADDRESS,

Jack Lewis *1439 E. Balto St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

66584

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Lenwood ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1418 Lenwood ave St.; 62 yrs., 10 mos., 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White5-STATUS,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.) Married

6-DATE OF BIRTH

Sept 28, 1860
(Month) (Day) (Year)

7-AGE

62 yrs., 10 mos., 6 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Machinist
0319-BIRTHPLACE,
(State or Country),Maryland

10-NAME OF FATHER,

Geo. W. Gross11-BIRTHPLACE OF FATHER
(State or Country),Maryland

12-MAIDEN NAME OF MOTHER

Don't know13-BIRTHPLACE OF MOTHER
(State or Country),Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary A. Gross

(Address)

1418 Lenwood Ave

15-

File

3761-3304

ROBERT R. KRAUTER,

Bertal Permit Clerk:

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 4th, 1922
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 4th 1922, to Aug 4th 1922, that I saw him alive on Aug 4th 1922, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Myocarditis
(Duration) 4 yrs., 4 mos., 4 ds.CONTRIBUTORY
(Secondary)(Signed) August Horn M. D.
August, 1922 (Address) 40 E 25th St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 4 yrs., 4 mos., 4 ds. In the State 4 yrs., 4 mos., 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Stemmers Run Cem

DATE OF BURIAL,

Aug 7, 1922

20-UNDERTAKER

John Reerich

ADDRESS

1008 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66585

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 2104 Cambridge St.;

2-FULL NAME

(Residence in Baltimore: No. 2104 Cambridge

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH

May 6, 1922

7-AGE,

yrs. 2 mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

2761-5 JIM ROBERT R. KRAUTER,

Filed..... 191

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 5, 1922

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1922, to Aug 5, 1922

that I saw him alive on Aug 5, 1922,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) William J. Smith M. D.

Aug 5, 1922 (Address) 401 N. Avenue

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Stanislaus Cem. Aug 6, 1922

20-UNDERTAKER ADDRESS

M. F. Sadowski 70 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66586

CERTIFICATE OF DEATH.

Registered No. 66586

1-PLACE OF DEATH

City of BALTIMORE: (No. St Marys Industries Bldg. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William H. Riley

(Residence in Baltimore: No.

627 W Baltimore

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-Single, Married, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

April

6

1853

(Month)

(Day)

(Year)

7-AGE,

69

yrs.

3

mos.

29

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

Construction

9-BIRTHPLACE,

(State or Country),

Balto. City.

10-NAME OF FATHER,

John Riley

11-BIRTHPLACE OF FATHER,

(State or Country), unknown

12-MAIDEN NAME OF MOTHER,

Margaret Ketch

13-BIRTHPLACE OF MOTHER,

(State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Elba B. Riley

(Address),

627 W Balt St

15-AUG 6 - 1922

ROBERT R. KRAUTER

Filed

192

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

5

1922

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY Rupture Coronary Artery (Secondary) sudden

(Signed) James M. Fenton M. D. (Coroner.)

Aug 5, 1922 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park

Aug 7, 1922

20-UNDERTAKER,

ADDRESS

Wm Cook, 507 E North Ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Stanislaus Negnerowicz
HEALTH DEPARTMENT-CITY OF BALTIMORE

D 66587

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single, Married, or Divorced.

Clergyman

6-DATE OF BIRTH.

April 15

1890

(Month)

(Day)

(Year)

7-AGE

32 yrs. 3 mos. 18 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Clergyman

9-BIRTHPLACE

(State or Country)

Poland

PARENTS.

10-NAME OF FATHER

Thomas Negnerowicz

11-BIRTHPLACE OF FATHER

(State or Country)

Poland

12-MAIDEN NAME OF MOTHER

Eltham Hendzierski

13-BIRTHPLACE OF MOTHER

(State or Country)

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Czeslaw Negnerowicz
1800 S. Hare St. 8

15-

AUG 6 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug - 3 - 1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or inquiry)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

182 (Address)

*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place

of death

..... yrs. mos. ds.

In the

State

..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Rosary

Aug 7

BURIAL PERMIT

1922

1800 S. Hare St. 8

With Nephritis & Hematuria. No evidence of sepsis.

Dr. Syme 22 S. Gray attending physician.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

peritoneum, etc.; *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66588

D 66588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *230 N. Duncan*ST.: *6* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *230 N. Duncan*ST.: *6* WARD.(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Josephine Cerny*6 DATE OF BIRTH (month, day, and year) *1858*7 AGE Years *64* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Bohemia*
(State or country)10 NAME OF FATHER *John Cerny*11 BIRTHPLACE OF FATHER (city or town) *Bohemia*
(State or country)12 MAIDEN NAME OF MOTHER *Anna Sismelich*13 BIRTHPLACE OF MOTHER (city or town) *Bohemia*
(State or country)

PARENTS

14 Informant *Josephine Cerny*
(Address) *230 N. Duncan*

15

Filed *AUG 6 - 1922*
2761-5-11A

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 4 1922*17 I HEREBY CERTIFY, That I attended deceased from *May 1 1922* to *Aug 4 1922*that I last saw him alive on *Aug 4 1922*and that death occurred, on the date stated above, at *6:30 A. M.*

The CAUSE OF DEATH* was as follows:

*Cerebral Coronary*CONTRIBUTORY (Secondary) *Cardiac Failure*
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed, *William J. Peterson*, M. D.
Aug 4 1922 (Address) *100 N. Howard*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer**Aug 7 1922*

20 UNDERTAKER

ADDRESS

*Frank Crockett**1906 Lombard*

66589
D 66589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2822 Mosher St. ST. 16 WARD)

2-FULL NAME

Amanda Beaveridge

(a) RESIDENCE. NO.

2822 Mosher St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female White Widow

6a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Robert Beaveridge

6 DATE OF BIRTH (month, day, and year)

1855

7 AGE

67

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

House wife

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Philadelphia
Pennsylvania

10 NAME OF FATHER

William Christy

PARENTS

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Scotland

12 MAIDEN NAME OF MOTHER

Martha Christy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Ireland

14

Informant
(Address)Edwin J. Beaveridge
2822 Mosher St.

15

AUG 7 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1922

17

HEREBY CERTIFY, That I attended deceased from
June 1920, to Aug 5, 1922,
that I last saw her alive on Aug 5, 1922;

and that death occurred, on the date stated above, at 12:20 a.m.

The CAUSE OF DEATH was as follows:

Cerebral thrombosis.

Immediate death.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Arteriosclerosis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptom and signs

(Signed)

John J. Gierder M. D.

19 (Address)

1123 Poplar Street

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

Aug 8 1922

20 UNDERTAKER

Wilbur W. Shivers

ADDRESS

1018 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66590 HEALTH DEPARTMENT—CITY OF BALTIMORE 66590

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital* ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Mrs. Martha Gary Varney*(a) RESIDENCE NO. *(Del. Roy, Va.)* ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *21* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *7* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Walter W. Varney*6 DATE OF BIRTH (month, day, and year) *Feb. 27, 1880*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
40 *5* *7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Culpepper Va.

10 NAME OF FATHER

Wm. Thos. Gary

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Wilmington North Carolina

12 MAIDEN NAME OF MOTHER

Lucy Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Culpepper Va.

PARENTS

14 Informant (Address)

Mrs. G. D. Donelson

15

*AUG 7 - 1922*ROBERT R. KRAUTER
Registrar

BUTLER STREET CHURCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 6, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *July 16, 1922* to *Aug. 6, 1922*, that I last saw her alive on *Aug. 6, 1922*, and that death occurred, on the date stated above, at *8:45 P. M.*

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of _____Was there an autopsy? *no*

What test confirmed diagnosis?

Blood tests

(Signed)

G. F. Goff

M. D.

, 19 (Address)

Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Chambers St.

DATE OF BURIAL

87 1922

20 UNDERTAKER

W. J. Tichner & Son

ADDRESS

North Ave. Pimlico

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66591

CERTIFICATE OF DEATH.

74 D 66591

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 N. Dallas ST., 8 WARD)

2. FULL NAME

Elizabeth M. Holtzman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1826 N. Dallas

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs.6 mos.24 ds.

How long in U. S., if of foreign birth?

Life yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 12 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1624

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Henry O. Holtzman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Christina M. Parr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

M. Henry O. Holtzman
1826 N. Dallas

15

Filed

AUG 7 1922ROBERT R. KRAUTER,Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 3, 1922, to Aug. 6, 1922,that I last saw him alive on Aug. 5, 1922,and that death occurred, on the date stated above, at 7 at m.

The CAUSE OF DEATH* was as follows:

Bacterial Spinal Meningitis
(Epidemic?)(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical symptoms(Signed) W. H. Singmaster, M. D.1922 (Address) 1613 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery Aug 7 1922

20 UNDERTAKER

Henry Brockman 1801 E. Eager

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66592

CERTIFICATE OF DEATH.

REGISTERED NO. 113 D 66592

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 Fentrell. St. WARD)

2-FULL NAME

Margaret Elaine Morris
329 Fentrell. St.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

—

6 DATE OF BIRTH (month, day, and year)

Jan 27-22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

6

10

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

—

(c) Name of employer

—

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Andrew J. Morris

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Monmouth

12 MAIDEN NAME OF MOTHER

Bessie Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant
(Address)

Andrew J. Morris
329 Fentrell.

15

AUG 7, 1922

ROBERT R. KRAUTER

Registrar

Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 6, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 20, 1922, to Aug 6, 1922,
that I last saw her alive on Aug 5, 1922,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

Acute - Cerebral

(duration)

yrs.

mos.

3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Clinical
Edw. V. Campbell M. D.

. 19

(Address)

208 K. Fulton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Michael's, St. Mary's
Co. Md.

Aug 9, 1922

20 UNDERTAKER

George J. Smith

ADDRESS

1000 W. Fayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66593

D 66593

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *602 E. George St.* ST.: *17* WARD)2-FULL NAME *Ada, Mrs. Davis*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *602 E. George St.* ST.: *17* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *6*mos. *9*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from *JUNE 24th*, 1922, to *August 5*, 1922, that I last saw *her* alive on *August 5*, 1922, and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

Enterocolitis (acute)(duration) yrs. mos. *12* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *at place of death*Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis? *Clinical findings*(Signed) *Burnell Fudge*, M. D., 19 (Address) *746 Dolphin St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

DOES

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66594

D 66594

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Fleet ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 2322 Fleet ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Infant5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) November 26, 19227 AGE Years 8 Months 10 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt10 NAME OF FATHER George J. Manno11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt12 MAIDEN NAME OF MOTHER Martha Hammer13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt14 Informant George J. Manno (Address) 2322 Fleet St.15 AUG 7 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 192217 I HEREBY CERTIFY, That I attended deceased from Aug 3 1922 to Aug 6 1922, that I last saw him live on Aug 5 1922and that death occurred, on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal ToxemiaCONTRIBUTORY (Secondary) Intestinal Toxemia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —Was there an autopsy? —

What test confirmed diagnosis?

(Signed) W. J. Gibby, M. D.19 PLACE OF BURIAL, CREMATION OR RE-NOVAL At home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL At home20 UNDERTAKER Wendell Dypfel & Son

DATE OF BURIAL

Aug 5 1922 ADDRESS 378 N. ...

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66595

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66595

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Ruxton ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Charles Wm. Nussear

(a) RESIDENCE NO.

1620 Ruxton

ST., 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annus Nussear

6 DATE OF BIRTH (month, day, and year)

Sept 18

1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

Jesse Nussear

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pen

D. M.

12 MAIDEN NAME OF MOTHER

Mary Harich

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Wm. D. Nussear

1620 Ruxton

15

AUG 7 - 1922

Wm. D. Nussear

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 27, 1922, to Aug 5, 1922.

that I last saw him alive on Aug 4, 1922.

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH was as follows:

Tobacco Pneumonia
Right & Left Lungs

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. M. Wheeler, M. D.

8/5, 1922 (Address) 422 Ruxton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Quincy Ridge

20 UNDERTAKER

Wendell Dyer

DATE OF BURIAL

Aug 8 1922

ADDRESS

378

157513
D 66596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-601
D 66596

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Laura V. Tuworth(a) RESIDENCE No. 1733 Linden Ave. City, 14 WARD Resident
(Usual place of abode)Length of residence in city or town where death occurred 50 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? 50 yrs. 7 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of (none)6 DATE OF BIRTH (month, day, and year) Dec. 10, 18727 AGE Years 50 Months 7 Days 26 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) Baltimore, Maryland
(State or country)10 NAME OF FATHER De Houtard11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland12 MAIDEN NAME OF MOTHER Lena Virginia13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland14 Informant JOHNS HOPKINS HOSPITAL
(Address)15 AUG 7, 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5, 192217 I HEREBY CERTIFY, That I attended deceased from August 1, 1922 to August 5, 1922that I last saw her alive on August 5, 1922and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia(duration) 8 yrs. 8 mos. — ds.CONTRIBUTORY Broncho-pneumonia
(Secondary)(duration) 7 yrs. — mos. 7 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Blood Examination(Signed) C. Sidney Raines, M. D., 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Mount Cemetery

DATE OF BURIAL

Aug 7, 1922

20 UNDERTAKER

ROBERT R. KRAVITZ

ADDRESS

102 NORTH AVENUE

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66597

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 Chelsea Ave ST.; 15 WARD)

2-FULL NAME Elizabeth Thies

(a) RESIDENCE. NO. 2122 Chelsea Ave ST., 15 WARD. Resident

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 54 yrs. ? mos. ? ds.

REGISTERED NO. 66597

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Henry Thies

6 DATE OF BIRTH (month, day, and year)

June 2-1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74 2 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town)

(State or country)

Hanover Germany

10 NAME OF FATHER

Carl Gilt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Hanover Germany

12 MAIDEN NAME OF MOTHER

Sophia Cords

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Hanover Germany

14

Informant (Address)

Miss Elizabeth S. Thies 2122 Chelsea Ave

15

AUG 7 - 1922

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 3rd 1922, to Aug 5 1922.

that I last saw her alive on July 19 1922.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxiation by Illuminating Gas (Suicidal)

(duration) yrs. mos. ds.

CONTRIBUTORY Malignant tumor of Intestines and Liver (duration) 0 yrs. 10 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Tumor mass in abdomen

(Signed) S. A. Dadds, M. D.

Aug 5 1922 (Address) 3101 Clifton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery Aug 7 1922

20 UNDERTAKER ADDRESS

Stewart Mower Co 408 W. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 66598

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST.: 14 WARD)

2-FULL NAME ADAM STEIN

(a) RESIDENCE. NO. 1413-Mt. Royal-Av. ST., 14 WARD. (Resident)

(Usual place of abode) 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 65 yrs. ? mos. ? ds.

MEDICAL CERTIFICATE OF DEATH

Male	White	Widowed
------	-------	---------

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Clamena Stein

6 DATE OF BIRTH (month, day, and year) Sept-1-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	11	5	

(a) Trade, profession or particular kind of work Manfr of Pipe Organs

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer (Self)

9 BIRTHPLACE (city or town) Hesse Darmstadt
(State or country) Germany

10 NAME OF FATHER Christopher Stein

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town).....unknown
(State or country) unknown

14 Informant Edwin A. Stein (Son)
(Address) 1413-Mt. Royal Av., City

15 Filed AUG 7 19 1922

16 DATE OF DEATH (month, day, and year) August 6 19 22

17 I HEREBY CERTIFY, That I attended deceased from
April 13, 1922, to August 6, 1922,
that I last saw him alive on August 6, 1922,
and that death occurred, on the date stated above, at 5.20 m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 3 mos. 23 ds.

CONTRIBUTORY (Secondary) Ugole English

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?.....no

What test confirmed diagnosis? *What a Gram stain*

(Signed) George F. Smith, M. D.

Aug 7 1924 (Address) R 430 Mary Lane Ave

State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

Druid Ridge Cemetery Aug-8-22¹⁹

NAME	ADDRESS
UNDERTAKER	

20 100-443887-1000

D 66599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 D 66599

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3502 Springdale Ave. ST. 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edward William Leeds

(Residence in Baltimore: No. 3502 Springdale Ave. St. 15 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH

Oct. 22nd, 1840

7-AGE

81 yrs. 9 mos. 15 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Panier 0.50

9-BIRTHPLACE, (State or Country),

Ohio

10-NAME OF FATHER,

Edward W. Leeds

11-BIRTHPLACE OF FATHER (State or Country),

Ohio

12-MAIDEN NAME OF MOTHER

Elizabeth H. H. H.

13-BIRTHPLACE OF MOTHER (State or Country),

Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsie H. Leeds

(Address) 3502 Springdale Ave.

15-

AUG 7 - 1922 191. ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH

August 6th, 1922

17- I HEREBY CERTIFY, That I attended deceased from

1919, to Aug 6th, 1922

that I saw him alive on April 1922

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows: An at-

tack of acute indigestion with

old age. He had been subject

to these attacks for 2 or 3 yrs.

but would really die on Aug. 3rd

was down stairs feeling good. I was

CONTRIBUTORY (Secondary) called in because

he was not taken until yesterday with

last attack. (Signed) D. H. Hoffman, M. D.

Aug 6th, 1922 (Address) 3402 Walbrook Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Burial Ground Aug. 9, 1922

20-UNDERTAKER ADDRESS

Wm. C. Mc... H. H. H.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66600

31 D 66600

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 Brant St. WARD 12)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 613 Brant St. ST. 12 WARD 12

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Friend6 DATE OF BIRTH (month, day, and year) Unknown 18947 AGE 28 Years — Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour(b) General nature of industry, business, or establishment in which employed (or employer) Labour(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Jamaica10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

PARENTS

14 Informant Rebecca Furquison (Address) 613 Brant St.

15

Filed AUG 7 1922

ROBERT A. KRAUTER,

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 3rd 1922 to Aug 4th 1922, that I last saw him live on Aug 3rd 1922, and that death occurred, on the date stated above, at 2:10 P.M.

The CAUSE OF DEATH* was as follows:

Acute pneumonia
phthisis - (consumption)(duration) 7 yrs. 1 mos. 20 ds.CONTRIBUTORY (Secondary) General exposure(duration) 7 yrs. 7 mos. 7 ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Physical Exam.(Signed) Edw. Hall M. D., 19 (Address) 426 E. 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Laurel Cn.DATE OF BURIAL Aug 7 192220 UNDERTAKER Mrs Robert A. ElliottADDRESS 17 E. 55

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66601

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

113

D 66601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 E 21

ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 326 E 21st

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 26-1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore md.

10 NAME OF FATHER

Howard F. Vogts

11 BIRTHPLACE OF FATHER (city or town)

Aberdeen md.

12 MAIDEN NAME OF MOTHER

Mary E. Baldwin

13 BIRTHPLACE OF MOTHER (city or town)

Belair Md.

14

Informant (Address)

Howard F. Vogts 326 E 21st

15

AUG 7 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 6, 1922, to Aug 7, 1922.

that I last saw him alive on Aug 7, 1922.

and that death occurred, on the date stated above, at 3:17 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 7 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald S. Torrey, M. D.

19 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Aberdeen Md. Aug 7 1922

20 UNDERTAKER

ADDRESS

Wm. Oak 502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state

THIS CASE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

066602 HEALTH DEPARTMENT—CITY OF BALTIMORE 066602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1628 Argyle St., 14 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1628 Argyle St., yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, 7-AGE, 8-OCCUPATION:

(a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), (Address),

15-AUG 7 - 1922

ROBERT R. KRAUTER, Buchel Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 17-I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary), (Duration), yrs., mos., ds., (Signed), M. D. (Coroner.), 1922, (Address),

*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents), At place of death, yrs., mos., ds., In the State, yrs., mos., ds., Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS,

21-UNDERWRITER, ADDRESS,

HEALTH DEPARTMENT—CITY OF BALTIMORE

66603

D 66603

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

833 Warner

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Fronney Brown

(a) RESIDENCE. NO.

833 Warner

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

23 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

18 83

7 AGE

Years

Months

Days

If LESS than
1 day, ... hrs.
or ... min.

39

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

House Wife

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city,
State or country)

Raleigh N.C.

10 NAME OF FATHER

James Wade

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Mary Gray

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

N.C.

14

Informant

(Address)

L. Brown
833 Warner

15

FILE

AUG 7 - 1922

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 5

1922

17

I HEREBY CERTIFY, That I attended deceased from

July 22, 1922, to July 25, 1922,

that I last saw her alive on July 22, 1922,

and that death occurred, on the date stated above, at 12:10 P. M.

The CAUSE OF DEATH* was as follows:

Consumption Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Morley Hoag M. D.

157 19th (Address) 729 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn

Aug 8/22

20 UNDERTAKER

ADDRESS

P. B. Gross 1405 McElherry

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66604

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

ST.: 1st WARD)

2-FULL NAME

(a) RESIDENCE, NO.

ST.: 1st WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos.

ds. How long in U. S., if of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16th 1845

7 AGE Years 77 Months 2 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

AUG 7, 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 4, 1922, to Aug 5, 1922, that I last saw him alive on Aug 5, 1922.

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Long, M. D.

19 (Address) 2701 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cem

Aug 6 1922

20 UNDERTAKER

ADDRESS

Peter Nicolaus 2040 Eastern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66605

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 McMechen ST.; 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Julius Wagner Shaffer

(a) RESIDENCE. NO.

125 McMechen

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) JAN 19-1902

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

6

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cashier 086

(b) General nature of industry, business, or establishment in which employed (or employer)

American Oil Co

(c) Name of employer

J. B. Baughman

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Thomas C. Shaffer

11 BIRTHPLACE OF FATHER (city or town)

Perryopolis

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Elizabeth Wagner

13 BIRTHPLACE OF MOTHER (city or town)

Perryopolis

(State or country)

Pennsylvania

14

Informant

(Address)

Thos. C. Shaffer 125 McMechen St.

15

Date

Aug 7, 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 31st, 1922, to Aug 4th, 1922,

that I last saw him alive on Aug. 4th, 1922,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. J. L. Fargo, M. D.

19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlaw Cemetery

Aug 7 1922

20 UNDERTAKER

W. M. Roulton

ADDRESS

2238 1/2

NOTE: Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 66606

CERTIFICATE OF DEATH

REGISTERED NO. C

D 66606

PLACE OF DEATH

CITY OF BALTIMORE (No. 1338 W. Lombard 3 ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frieda Ester Doroch

(Residence in Baltimore: No. 1338 W. Lombard St.: yrs. 4 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH March 17, 1922 (Month) (Day) (Year)

7-AGE 4 yrs. 20 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE (State or country) Baeto Ind

10-NAME OF FATHER John C. Doroch

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Pauline J. Stamer

13-BIRTHPLACE OF MOTHER (State or country) Boston Mass

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John C. Doroch

(Address) 1338 W. Lombard

AUG 7 1922

Filed 1922

ROBERT R. KRAUTER

Burial Form

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Aug 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31, 1922, to Aug 5, 1922, that I saw her alive on Aug 5, 1922, and that death occurred, on the date stated above, at 12.40 P m. The CAUSE OF DEATH* was as follows:

Congenital Hydrocephalus
and Rickets
(Duration) since birth yrs. mos. ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds. (Signed) Vernon H. Gordon M. D. (Address) 750 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Lyden Park DATE OF BURIAL Aug 7 1922

20-UNDERTAKER W. Witzke ADDRESS 15310 Lombard

D 66607

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66607

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hooper

(a) RESIDENCE NO. 127 Hill St.

ST. 22 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

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8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Factory worker

(b) General nature of industry, business, or establishment in which employed (or employer)

Tobacco

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Logan Hooper

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Richardson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

Hospital Records,

(Address)

Municipal Hospital.

15

AUG 7 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 25, 19 22, to August 3, 19 22.

that I last saw her alive on August 3, 19 22.

and that death occurred, on the date stated above, at 7:25 P.M.

The CAUSE OF DEATH* was as follows:

Tubo-ovarian abscess with pelvic peritonitis

(duration)

yrs.

3

mos.

ds.

CONTRIBUTORY (Secondary)

Post operative shock

(duration)

yrs.

4

mos.

hrs

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of Aug 3-1922

Was there an autopsy? no

What test confirmed diagnosis?

Exam.

(Signed)

Richardson Jayne M. D.

8/4/22

Address

Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mt. Auburn Ct

UNDERTAKER

W. E. Brown Son

DATE OF BURIAL

Aug 7 1922

ADDRESS

1074 N. Monto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

157323

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66608

CERTIFICATE OF DEATH.

D 66608

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

JOHNS HOPKINS HOSPITAL

WARD) _____

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Amy Bennett

(a) RESIDENCE NO.

104 S. Duncan St.

WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white single

5a If married, widowed, or divorced

HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year)

Dec. 29, 1922

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

7 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

Emmanuel Bennett

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Katherine Hasenai

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant
(Address)

JOHNS HOPKINS HOSPITAL

15

AUG 7, 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August 6, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 22, 1922, to August 6, 1922

that I last saw her alive on August 6, 1922

and that death occurred, on the date stated above, at 12:05 P. M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Over)

(duration)

yrs.

mos.

7 ds.

CONTRIBUTORY 1st, 2nd + 3rd degree burns
(Secondary)

(duration)

yrs.

mos.

18 ds.

18 Where was disease contracted

if not at place of death?

104 S. Duncan St.

Did an operation precede death?

No

Date of _____

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Warfield M. Fran, M. D.

8/6, 1922 (Address)

J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Oak Lawn Cem

Aug 7, 1922

20 UNDERTAKER

ADDRESS

Peter Nicolaus 2040 Eastern A

Eastern A

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66609

CERTIFICATE OF DEATH.

31 D 66609

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 Furrow ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rosaline Strickling

(a) RESIDENCE No.

427 Furrow

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 21-1905

7 AGE

Years

Months

Days

17

6

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoe factory

(b) General nature of industry, business, or establishment in which employed (or employer)

Pulaski & McHenry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

William E. Strickling

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto.

12 MAIDEN NAME OF MOTHER

Mamie Lindner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto.

14

Informant (Address)

Mrs. Ida Lindner 427 J. Cantelero

15

Filed

19

ROBERT R. KRAUTER, Registrar

AUG 7-1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1921, to Aug. 5, 1922.

that I last saw him alive on Aug. 5, 1922.

and that death occurred, on the date stated above, at 12⁰⁰ M.

The CAUSE OF DEATH* was as follows:

Pulm. Thc.

(duration)

yrs. 9

mos.

ds.

CONTRIBUTORY (Secondary)

Endocarditis

(duration)

yrs.

mos. 3

ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dudley P. Bower M. D.

19 (Address) 904 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

The New Cathedral

DATE OF BURIAL

Aug 8 1922

20 UNDERWRITER MRS. N. S. PINK.

ADDRESS

FUNERAL DIRECTORS

1787 N. B. ST.

HEALTH DEPARTMENT CITY OF BALTIMORE

D 66610

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *121 Biddle* ST. *10* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Annie Victoria Sawyer*(Residence in Baltimore: No. *121 W. Biddle* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Caucasian*5-SINGLE
MARRIED
WIDOWED
OR DIVORCED.
(Write the word.)*Single*

6-DATE OF BIRTH

March 24th, 1911
(Month) (Day) (Year)

7-AGE,

7 yrs. *4* mos. ds.If LESS than 1 day,
.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

*Home Child*9-BIRTHPLACE,
(State or Country),*Baltimore, Md.*

10-NAME OF FATHER,

*Lloyd Sawyer*11-BIRTHPLACE OF FATHER
(State or Country),*Tenn.*

12-MAIDEN NAME OF MOTHER

*Anna Phillips*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore, Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lloyd Sawyer

(Address)

121 Biddle St.

15-

ROBERT H. KNAUER,

Burial Permit Clerk

AUG 7, 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 5th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug. 3rd 1922 to Aug. 5th 1922*that I saw him alive on *Aug. 4th, 1922*and that death occurred, on the date stated above, *3:30* hr.

The CAUSE OF DEATH* was as follows:

Factor - entrance

.....

.....

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Malaria*

..... (Duration) yrs. mos. ds.

(Signed) *A. L. L. (M.D.)*....., 1912 (Address) *924 N. 3rd St.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Midway Cemetery

20-UNDERTAKER

*George H. Holland*ADDRESS *1681**Calver*

important. See instructions on back of certificate.

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66611

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St., *15* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1952 Ridgewood Ave* St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH

July

24

1922

7-AGE,

1

yrs.

6

mos.

1

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER,

Ruben Allen

11-BIRTHPLACE OF FATHER, (State or Country).

Carroll Co Md

12-MAIDEN NAME OF MOTHER

Emma Buckenham

13-BIRTHPLACE OF MOTHER, (State or Country).

Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Richard Allen

(Address)

1952 Ridgewood Ave

15-

FEB **AUG 7 - 1922**

ROBERT R. KRAUTER Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 6

1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Enteric Meningitis due to accidental fall of 17 feet (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Signed) *Joseph Potter* M. D.

8-7-22 1922 (Address) *508 E North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Stone Chopple

Aug 8, 1922

20-UNDERTAKER,

ADDRESS

Joseph Shreve

221 N Broadway

D 66612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1351 N. Stricker ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1351 N. Stricker St.; 5 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

June 18, 1912 (Month) (Day) (Year)

7-AGE,

3.5 yrs., 1 mos., 18 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Lawyer

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed AUG 7 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 1, 1922 to Aug 5, 1922
that I saw him alive on Aug 3, 1922

and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitis

CONTRIBUTORY (Secondary)

(Duration) yrs. 3 mos. ds.

(Signed) J. T. Coleman, M.D.

Aug 6, 1922 (Address) 9337 McCulloch

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

20-UNDERTAKER

Jas. H. Deen

DATE OF BURIAL,

Aug 7, 1922

ADDRESS

1312 Greenmoor

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66613

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geneva Howard

(a) RESIDENCE NO. 215 First St., Brooklyn ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Solon Howard

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE 19 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Georgia (State or country)

10 NAME OF FATHER Lucius Davis

11 BIRTHPLACE OF FATHER (city or town) Georgia (State or country)

12 MAIDEN NAME OF MOTHER Mary I. Solomon

13 BIRTHPLACE OF MOTHER (city or town) Georgia (State or country)

14 Informant Hospital Records (Address) H.S.H.

15 AUG 7 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to Aug. 5, 1922, that I last saw her alive on Aug. 5, 1922, and that death occurred, on the date stated above, at 4 a. m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray (Signed) Francis P. Delaney, M.D.

8-5-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Farmace Branch

20 UNDERTAKER John F. Denny

DATE OF BURIAL

Aug 8 1922

ADDRESS

715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M & T 1500 Hka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66614

CERTIFICATE OF DEATH.

177

D 66614

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 402 East 28th ST., 12 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl G. Bentz

(a) RESIDENCE NO. 402 E-28th ST., WARD (Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, or write the word

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28, 1861

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 AUG 7 - 1922 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5-1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to Aug 5, 1922, that I last saw him alive on Aug 5, 1922, and that death occurred, on the date stated above, at 4:10 P m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis with Motor Paralysis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Suspected accidental arsenical poisoning.

(duration) yrs. mos. ds.

18 Where was disease contracted? Home

19 Place of death? St. Carmine's Hospital

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. T. Carmichael, M. D.

, 19 (Address) 1209 Madison av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

London Park Aug 8, 1922 William Cooks 502 E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66615

CERTIFICATE OF DEATH.

D 66615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wilhelm(a) RESIDENCE No. 2132 Cliver St.ST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) cut down 18657 AGE Years Months Days If LESS than 1 day, hrs. or min. 57 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brush Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Chas. Wilhelm11 BIRTHPLACE OF FATHER (city or town) Balto., Md. (State or country)12 MAIDEN NAME OF MOTHER Emma Morris13 BIRTHPLACE OF MOTHER (city or town) Balto., Md. (State or country)14 Informant Hospital Records, (Address) Municipal Hospital.15 AUG 7 - 1922 ROBERT N. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 19 22

17

I HEREBY CERTIFY, That I attended deceased from June 10 19 22 to August 5 19 22, that I last saw him alive on August 5 19 22, and that death occurred, on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumomononosis

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos. ds.(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde M. Huer M. D.8/7/19 22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Park

DATE OF BURIAL

8/7 1922

20 UNDERTAKER

ADDRESS

William Cook502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66616

CERTIFICATE OF DEATH.

D 66616

1-PLACE OF DEATH U.S.V.HOSPITAL#56-

REGISTERED NO.

CITY OF BALTIMORE: (No. Ft. McHenry, Md.

ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME FRANK D. JOHNSTON,

(a) RESIDENCE No. Fourth Ave. Nebraska City, Nebr. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nebraska (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant HOSPITAL RECORDS, (Address) Ft. McHenry, Md.

15 AUG 7 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5, 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1922 to August 5, 19 22, that I last saw him alive on August 5, 1922, and that death occurred, on the date stated above, at 10:30 p.m. The CAUSE OF DEATH* was as follows:

Angina, pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? -- Date of --

Was there an autopsy? --

What test confirmed diagnosis? Clinical Report

(Signed) Surgeon (R) M. D.

8/5/22 (Address) U.S.V. HOSP. #56, Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Nebraska City, Neb. Aug 7, 1922

Address 1127

Funeral Home E. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66617

CERTIFICATE OF DEATH.

D 66617

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 N. 40th St. ST.: 9 WARD)2-FULL NAME Hola. B. Lynam.(Residence in Baltimore: No. 1112 N. 40th St. St.: 43 yrs., 0 mos., 17 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE. <u>White</u>	5-STATUS. MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <u>Widow</u>
6-DATE OF BIRTH, <u>Dec 20th</u> , 1878. (Month) (Day) (Year)		
7-AGE, <u>43</u> yrs., <u>0</u> mos., <u>17</u> ds. If LESS than 1 day, ... hrs. or ... min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>House work</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>at home</u>		
9-BIRTHPLACE, (State or Country), <u>Balto City, Md.</u>		
PARENTS.	10-NAME OF FATHER, <u>Wm. H. Kennedy</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Maryland</u>	
	12-MAIDEN NAME OF MOTHER, <u>Janny Morris</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Maryland</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Janny Kennedy
(Address) 1112 N. 40th St.15- AUG 7 - 1922 ROBERT R. KRAUTER,
Filed..... 191.....
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, August 6th, 1922.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from June 9th 1922, to Aug 6 1922, that I saw her alive on Aug 6 1922, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration)..... yrs. 6 mos. ds.CONTRIBUTORY
(Secondary)(Signed) D. R. W. Smith M. D.
Aug 7, 1922 (Address) 865 W. 36th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, St. Mary's Hospital 8/8, 192220-UNDERTAKER ADDRESS J. WALTER DAVIS 13307 Fairview

FUNERAL DIRECTOR

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 66618

66618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 793 St. Peter ST., 21 WARD)2-FULL NAME Charles E. Van Sant(a) RESIDENCE NO. 793 St. Peter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofElizabeth Vansant Greening

6 DATE OF BIRTH (month, day, and year)

Nov 14 1852

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.69823

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Excelsior Steamboat Co9 BIRTHPLACE (city or town)
(State or country)Is alto
ind

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town)

11

(State or country)

12 MAIDEN NAME OF MOTHER

11

13 BIRTHPLACE OF MOTHER (city or town)

11

(State or country)

14

Informant
(Address)Mrs. Elizabeth A. Kinsley
793 St. Peter St.

15

AUG 7 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 30, 1922, to Aug 6, 1922.that I last saw him alive on Aug 5, 1922.and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

ApoplexyCONTRIBUTORY
(Secondary)

(duration) yrs. mos. da.

(duration) 1 yrs. mos. da.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

8/7/22 (Address) 729 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery Aug 9 1922

20 UNDERTAKER

ADDRESS

James Dignan & Son 1000 S. Paca St.

PHYSICIANS should state EXACTLY Cause of Death in plain terms, so that it may be properly classified. Exact statement of Cause of Death is very important. See instructions on back of certificates.

D 66619

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2526 Eager Place ST.;

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

1922

Burial Permit Clerk,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

7-24-22

to

8-7-22

that I last saw him live on

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia with
(6 1/2 months)

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922

Address

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Vincent Cemetery

20 UNDERTAKER

George J. Puth 1735 Hayford Ave.

D 66620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 WheatleST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William H. Haber

(a) RESIDENCE. NO.

1021 Wheatle

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 8/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

Martin Haber

11 BIRTHPLACE OF FATHER (city or town) (State or country)

B. Bohemia

12 MAIDEN NAME OF MOTHER

Herman Polara

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

14

Informant (Address)

Martin Haber1021 W. WheatleRobert T. H. H. H. H.

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 6 1922

17

I HEREBY CERTIFY, That I attended deceased from July 26, 1922, to Aug 6, 1922, that I last saw him live on Aug 6, 1922, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pneumophoroneuritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

General debility

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

unknownDid an operation precede death? No Date of

Was there an autopsy?

No

What was the cause of death?

Pneumophoroneuritis(Signed) Robert T. H. H. H.Address 800 N. WallCity BaltimoreState Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balt. HillAug 8 1922

20 UNDERTAKER

ADDRESS

Frederick G. G. G.1806 E. Broadway

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66621

CERTIFICATE OF DEATH.

161-01 D 66621

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 S Fremont ST.: 21

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis Stanley Hook

(Residence in Baltimore: No. 604 S Fremont St.;

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) single

6-DATE OF BIRTH,

Aug

6th, 1922

(Month)

(Day)

(Year)

7-AGE,

If LESS than 1 day,

5 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

none

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Baltimore, Md

10-NAME OF FATHER,

Chas Augustine Hook

11-BIRTHPLACE OF FATHER (State or Country).

Balto. Md

12-MAIDEN NAME OF MOTHER

Dorothy Minnie Meyer

13-BIRTHPLACE OF MOTHER (State or Country).

Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas A Hook

(Address)

604 S Fremont St

15-

Filed

Robert P. Harrison,

Registrar.

1922

Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug

6th, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

191

to

191

that I saw him alive on Aug 6th 1922

and that death occurred, on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity 7 months gestation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. E. Bullion M. D. 8/6/22, 191... (Address) 654 Columbia Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Mary Cemetery, Towson

Aug 7th, 1922

20-UNDERTAKER

ADDRESS

Geo Lemlock & Son

647 W Pratt St

D 66622

HEALTH DEPARTMENT—CITY OF BALTIMORE D 66622

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery and Childs Hosp. St.: 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madeleine Powell

(a) RESIDENCE. No. Nursery and Childs Hosp. St., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

female

white

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

1

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Queen Ann's Co. (State or country) Maryland.

10 NAME OF FATHER Lemeal Powell

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Naomi Solaway

13 BIRTHPLACE OF MOTHER (city or town) Chester-town, Maryland.

14

Informant (Address)

15 1922

19

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 12, 1922 to Aug. 6, 1922

that I last saw her alive on Aug. 6, 1922

and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Intoxication

(duration) 0 yrs. 0 mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health,

1922

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66623

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

66623

PLACE OF DEATH
CITY OF BALTIMORE (No. 2149 Division St. 14 WARD)
FULL NAME Adam Boehm
(Residence in Baltimore: No. 2149 Division St. 40 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married
6 DATE OF BIRTH Sept. 22, 1856
7 AGE 65 yrs. 10 mos. 14 ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work Restaurant 086 (b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE (State or country) Bavaria
10 NAME OF FATHER Paulus Boehm
11 BIRTHPLACE OF FATHER (State or country) Germany
12 MAIDEN NAME OF MOTHER not known
13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Adam Boehm
(Address) 2149 Division St

15 Robert P. Harrison,

Filed

191

1922

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 5, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1922 to August 5, 1922
that I saw him alive on August 4, 1922
and that death occurred, on the date stated above, at 6:30 a.m.
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(apoplexy)

(Duration) yrs. mos. ds.

Contributory Indefinite
(SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Harry M. Arthur M. D.
Aug. 6, 1922 (Address) 1426 N. Laurel St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Cathedral

Aug 8 - 1922

20 UNDERTAKER

ADDRESS 617 N.

H. Brauning

Schroeder St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66624

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH #

CITY OF BALTIMORE: (No. 821 China St.,

ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helma Little

(Residence in Baltimore: No. 821 China

St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female
4-COLOR OR RACE Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, April 4, 1922
(Month) 4 (Day) 4 (Year) 1922

7-AGE, yrs. 5 mos. ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Ind.

10-NAME OF FATHER, William Little

11-BIRTHPLACE OF FATHER, Grandel County, Md.

12-MAIDEN NAME OF MOTHER, Maggie Brumford

13-BIRTHPLACE OF MOTHER, Grandel County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leroy Green

(Address) 821 China St.

15-

Filed..... Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 6, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1922, to Aug 6, 1922, that I saw her alive on Aug 4, 1922, and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Decomposition Intestinalis (Stasis)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malignant Maffery

(Signed) W. J. Green M. D.

Aug. 7, 1922 (Address) St. Agnes Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Grandel County, July 7, 1922

20-UNDERTAKER, ADDRESS, Mrs. Geo. H. Hooper 406 N. Conway St.

-1922

Burial Permit Clerk.

D 66625

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Aliceama ST., 3 WARD)2-FULL NAME Adam Polak(a) RESIDENCE NO. 1510 Aliceama ST., _____ WARD _____
(Usual place of abode)Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Nov. 10-19217 AGE Years Months Days If LESS than 1 day, hrs. or min.
8 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Simon Polak11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland12 MAIDEN NAME OF MOTHER Mary Mondy13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland14 Informant Simon Polak (Address) 1510 Aliceama15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19 2217 I HEREBY CERTIFY, That I attended deceased from August 1, 1922, to August 6, 1922, that I last saw him alive on August 6, 1922, and that death occurred, on the date stated above, at 1 p. m. The CAUSE OF DEATH* was as follows:acute illis colitis(duration) yrs. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis?

(Signed) P. A. Janney, Jr. M. D.(Address) 2429 East

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Rosary8/8 1922

UNDERTAKER

ADDRESS

John Gialkowski1618 East

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

927

Burial Permit Clerk.

D 66626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 53 Main St. Hillsdale ST., 28 WARD)

2-FULL NAME

Infant Waltman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

53 Main St. Hillsdale Wd.ST., 28 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteSingle5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug. 6" 1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.Premature Birth

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore, Md.

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Anna Waltman13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Hillsdale, Md.

14

Informant

(Address)

Anna Waltman53 Main St. Hillsdale, Md.

15

Filed Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6" 1922

17

I HEREBY CERTIFY, That I attended deceased from
Aug. 6, 1922 to Aug. 6, 1922,
that I last saw him alive on Aug. 6, 1922,
and that death occurred, on the date stated above, at 5:40 P. m.
The CAUSE OF DEATH* was as follows:Premature Birth.
About 6 mos.CONTRIBUTORY (Secondary) History of Fall from
days prior to delivery
(duration) yrs. mos. ds.
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

A. Meritt Spill M. D.

Address

3705 Liberty St. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

ROYALGood Lawn Co.

20 UNDERTAKER

ADDRESS

Joseph B. Cook1003 W. Balt

1922

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 W. Saratoga St. ST. 4th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. George

(a) RESIDENCE No. 209 W. Saratoga

ST. 4th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Frederick A. George

6 DATE OF BIRTH (month, day, and year) Nov 16, 1848

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

73

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Thomas Lautner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Teresa Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14

Informant
(Address)

15

Filed

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 1922

17

I HEREBY CERTIFY, That I attended deceased from July 1st, 1922, to August 5th, 1922.

that I last saw her alive on August 4th, 1922.

and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast. Patholog

Carcinoma of lung. Clinical.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Acidosis. Cardiac.

(Secondary) Asthenia (duration) yrs. mos. 3 ds.

18 Where was disease contracted
if not at place of death? *****

Did an operation precede death? Yes Date of 9-14-21

Was there an autopsy? No

What test confirmed diagnosis? Clinical, Patholog

(Signature) M. D.

(Address) 24 N. Fullin, Ok

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

1922

Burial Permit Clerk

D 66628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 N. Baltimore ST., 19 WARD)

2-FULL NAME

Mary Catherine Graham

(a) RESIDENCE NO.

1466 N. Baltimore ST.

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

66 yrs. 4 mos.

ds.

How long in U. S., if of foreign birth?

Life

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John W. Graham

6 DATE OF BIRTH (month, day, and year)

Nov 19

7 AGE

Years

Months

Days

66

4

—

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Andrew Jamison

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Margaret S. Daniels

15

AUG 3 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 7 1922

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1922 to Aug 6, 1922 that I last saw him alive on August 6, 1922

and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Dilatation Aortic, Endo Metritis

CONTRIBUTORY (Secondary)

(duration) yrs. 9 mos. ds. Dropsy & Emphysema

(duration) yrs. 1 mos. ds. Hemiplegia

18 Where was disease contracted? if not at place of death?

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

assigned) C. R. Davis M. D.

19 (Address)

2108 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

DATE OF BURIAL

Aug. 10 1922

20 UNDERTAKER

Henry Hooker

ADDRESS

1301 E. Bay St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66629

66629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *105 Hope Retreat* ST. *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frances A Beckman

(a) RESIDENCE. NO.

Holy Redeemer Cemetery Md.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. *6* mos. *0* ds.

How long in U. S., if of foreign birth?

2 yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 10-1886

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*35**8**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Gardenville Md*

10 NAME OF FATHER

Peter Beckman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Gardenville Md

12 MAIDEN NAME OF MOTHER

Catherine Bruder

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Gardenville Md

14

Informant

(Address)

*Catherine Beckman
Holy Redeemer Cemetery*

15

*Aug 8-1922**ROBERT R. KRAUTER**Burial Permit*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 7

1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 7, 1924, to Aug 7, 1922

that I last saw him alive on

Aug 16, 1922

and that death occurred, on the date stated above, at

5:15 A. m.

The CAUSE OF DEATH* was as follows:

*Diarrhoea and
Enteritis*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)*Amnesia*

(duration)

30 yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical examination

(Signed)

C. B. Enos

M. D.

Address)

*105 Hope Retreat**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer Cemetery**Aug 10 1922*

20 UNDERTAKER

Henry Wood Sun

ADDRESS

1307 E. Bay St

107324 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66631

D 66631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) JOHNS HOPKINS HOSPITAL, 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Egan

(a) RESIDENCE NO. 527 W. Lexington St., City, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mary Egan, (Mother)

6 DATE OF BIRTH (month, day, and year) March 16, 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

4 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Mary League

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14 Informant JOHNS HOPKINS HOSPITAL

15 AUG 8 - 1922

Filed

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from

July 22, 1922, to Aug 4, 1922,

that I last saw her alive on Aug 4, 1922,

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Diseases not dysentery

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) T. B. Gay, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

JOHNS HOPKINS HOSPITAL 8/4 1922

20 UNDERTAKER

ADDRESS

157325 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 66632

CERTIFICATE OF DEATH.

D 66632

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Laurence Tucker(a) RESIDENCE NO. 606 Archer St., City ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single6a If married, widowed, or divorced
HUSBAND of
WIFE of6 DATE OF BIRTH (month, day, and year) June 18 19217 AGE Years Months Days If LESS than 1 day, hrs. or min.
1 1 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

AUG 8 - 1922ROBERT A. KRAUTER,Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6 1922

17

I HEREBY CERTIFY, That I attended deceased from July 22, 1922, to August 6, 1922, that I last saw her alive on August 6, 1922, and that death occurred, on the date stated above, at 6:40 A m.

The CAUSE OF DEATH* was as follows:

Dysentery, Flexner type(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? HomeDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Stool Culture(Signed) T B Gay, M. D., 19 (Address) John Hop Kins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

St. Aieburn Aug 8 1922

20 UNDERTAKER

ADDRESS 172John H. Tradman Wick St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

66633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 33 75 Chestnut Ave ST. 13 WARD 13

2-FULL NAME Daniel L Krebs

(a) RESIDENCE. No. 33 75 Chestnut Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary C. Krebs Oct 30-1882

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 69 9 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor 040

(b) General nature of industry, business, or establishment in which employed (or employer) York Co Pa.

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Pa.

10 NAME OF FATHER Jeremiah Krebs

11 BIRTHPLACE OF FATHER (city or town). (State or country) Pa.

12 MAIDEN NAME OF MOTHER Emma M. Mills

13 BIRTHPLACE OF MOTHER (city or town). (State or country) Pa.

14 Informant (Address) Mary C. Krebs 33 25 Chestnut Ave

15 AUG 6 - 1922

Burial Permit Clerk

90 D 66633 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

16 DATE OF DEATH (month, day, and year) Aug 6 1922

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1922, to Aug 5, 1922, that I last saw him live on Aug 5, 1922, and that death occurred, on the date stated above, at 6. A m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY Chronic Arthritis (Secondary) (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Durrin M. D.

1922 (Address) 800 N 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Line Boro. Md Aug 9 22

20 UNDERTAKER ADDRESS

A. S. Marshall 3539 Fall Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66634

CERTIFICATE OF DEATH.

129 D 66634

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1650 E. Pratt ST., 3 WARD)

2-FULL NAME

(a) RESIDENCE No. 1650 E. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Gephhardt

6 DATE OF BIRTH (month, day, and year) Nov 15-53

7 AGE Years 68 Months 8 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer in Lumber Yard

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City of Baltimore

10 NAME OF FATHER John Gephhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Annie Gephhardt 1650 E. Pratt St.

15 AUG 8 - 1922 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7/1922

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1922 to Aug 7, 1922, that I last saw him alive on Aug 6, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chemical Exam.

(Signed) A. T. Rice, M. D.

Aug 8, 1922 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Philip Hennig

DATE OF BURIAL

8/9/1922

ADDRESS 306

O'Leary

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66635

CERTIFICATE OF DEATH.

31

D 66635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 N. Fremont Ave ST. 17 WARD)2-FULL NAME Fred. N. Schmuck

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 531 N. Fremont Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced
HUSBAND of Margaret Schmuck6 DATE OF BIRTH (month, day, and year) Oct. 27 18717 AGE Years Months Days If LESS than 1 day, hrs. or min.
50 9 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Shaker(b) General nature of industry, business, or establishment in which employed (or employer) 88

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)10 NAME OF FATHER Jacob Schmuck11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany14 Informant Fred N. Schmuck Jr
(Address) 531 N. Fremont Ave15 Filed Aug 8 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7- 192217 I HEREBY CERTIFY, That I attended deceased from Apr. 13th, 1922, to Aug 7th, 1922, that I last saw him alive on Aug 7th, 1922, and that death occurred, on the date stated above, at 12.05 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 3 mos. 23 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? for Tuberculosis
(Signed) Robt. J. Murray, M. D.7, 1922 (Address) 531 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Woodlawn Aug 9 1922

20 UNDERTAKER ADDRESS

Geo W Little EDMONDSON AVE.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

D 66636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

AUG 8 - 1922

ROBERT R. KRAUTH

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 7, 1922, to Aug. 7, 1922,

that I last saw him alive on Aug. 7, 1922,

and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 1/2 - 7 mos.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Gray, M. D.

17, 1922 (Address) Johns Hopkins Hospital

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cemetery

August 8, 1922

20 UNDERTAKER

ADDRESS

M. J. Sadowski

705 S. Ann St.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 66637

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 Glyndon

ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry E. Rooney

(a) RESIDENCE No. 1307 Glyndon Ave

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year) July 12th 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 2 weeks 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

10 NAME OF FATHER Henry E. Rooney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Madilene Hess

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Henry E. Rooney

(Address) 1307 Glyndon Ave

15 AUG 8 - 1922 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7th. 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1922, to Aug 1, 1922, that I last saw him alive on Aug 5, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectases
Microcephalus

(duration) yrs. mos. ds.

CONTRIBUTORY Malnutrition (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward V. Quaschnick M. D.

(Address) 24 N. Fullam St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

1600 Cathedral Cemetery Aug 8 1922

20 UNDERTAKER

ADDRESS

Geo. Linboeck & Son 647 N. Bath

1578638

HEALTH DEPARTMENT—CITY OF BALTIMORE

66638

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Francis Robinson

(a) RESIDENCE NO.

4307, Gilmore St.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
WIFE ofLucy Robinson (mother)6 DATE OF BIRTH (month, day, and year) May 12, 19227 AGE Years Months Days If LESS than 1 day, hrs. or min.
2 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Wm Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Lucy Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

AUG 8 - 1922ROBERT A. KRAUTERBurial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 192217 I HEREBY CERTIFY, That I attended deceased from July 21, 1922 to Aug. 7 1922that I last saw her alive on Aug 7 1922and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute gastro-intestinal indigestion(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? HomeDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) Blount Mason, M. D.8/7, 1922 Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Interment

20 UNDERTAKER

Sam H. Chase

DATE OF BURIAL

8-8-22

ADDRESS

1400 Maple

TIONS are very important. See instructions on back of certificates.

Physicians should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

157524 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66639

CERTIFICATE OF DEATH.

32 D 66639

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9) JOHNS HOPKINS HOSPITAL, 9 WARD)

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

Henry Parr, Jr.

(a) RESIDENCE NO.

2541 Greenmount Ave.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)

Male White

Single

6a If married, widowed, or divorced

HUSBAND of

or WIFE of

Henry Parr (Father)

6 DATE OF BIRTH (month, day, and year)

April 16 - 1919

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Child

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Maryland

10 NAME OF FATHER

Henry Parr

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

M. M. Stout

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore

14

Informant
(Address)

JOHNS HOPKINS HOSPITAL

15

Aug 8 - 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 7 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1922, to Aug 7, 1922.

that I last saw him live on Aug 7, 1922.

and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Smear and culture

(Signed) Cleburne M. D.

8/7, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Cathlamet

20 UNDERTAKER

M. C. Cook

DATE OF BURIAL

8/9 1922

ADDRESS

502 E. 11th St.

Specimen should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66640

118-002
D 66640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hosp

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 11 WARD)

2-FULL NAME

James Hand

(a) RESIDENCE NO.

Chas. & Mt Royal Ave

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs. mos. ds.

How long in U. S., if of foreign birth?

Yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

6 DATE OF BIRTH (month, day, and year)

1842

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

John Hand

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant

(Address)

Catherine M. Cornuch
118 Polk St

15

Informant

(Address)

ROBERT R. KNAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5 1922

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1922, to Aug 5, 1922, that I last saw him alive on Aug 5, 1922, and that death occurred, on the date stated above, at 11:50 P. M.

The CAUSE OF DEATH* was as follows:

Partial intestinal obstruction

CONTRIBUTORY (duration) yrs. mos. 2 ds. Bilateral inguinal hernia containing small intestine

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. Richardson Jones M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St Peters Cemetery

8/8 1922

20 UNDERTAKER

ADDRESS

William Cook

502 E. Harp

D 66641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66641

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1531 McCulloch ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1531 McCulloch ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1879

7 AGE Years 43 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address) Carrie Gibbs 416 Orchard St.

15 Filed

19

ROBERT A. KRAUTER Registrar

AUG 8 - 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1922

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922, to Aug 5, 1922,

that I last saw him alive on Aug 4, 1922,

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cholelithiasis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood test (Signed) Chas. H. H. M. D.

(Address) 1531 McCulloch St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Cem Aug 9 1922

20 UNDERTAKER

ADDRESS

Samuel Hensley Biddle

is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly claimed.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66642

CERTIFICATE OF DEATH.

D 66642

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. *1302 N. Mount* St. *15* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1302 N. Mount St.* St.; *life* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH *Dec 10* 880 (Month) (Day) (Year)

7-AGE *42* If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). *Laundress*

9-BIRTHPLACE, (State or Country). *Baltimore*

10-NAME OF FATHER, *Chas Thompson*

11-BIRTHPLACE OF FATHER, (State or Country). *Ind*

12-MAIDEN NAME OF MOTHER, *Eliza Thompson*

13-BIRTHPLACE OF MOTHER, (State or Country). *Ind*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo N White*

(Address) *1302 N. Mount St*

15-

Filed *AUG 8 - 1922* ROBERT R. KRAUTER

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Aug 4* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

1922 (Address) *1302 N. Mount St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Laurel Ave. Aug 9

20-UNDERTAKER, ADDRESS *Laurel Ave. 378*

Laurel Ave. 378

is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified.

D 66643 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66643

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *1133 Polino* St. *11* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *1133 Polino* St.; yrs.,..... mos..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

colored

5-Single, Married, *mar*
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH.

Jan 28

122

(Month)

(Day)

(Year)

7-AGE,

yrs. *6*

mos.

ds.

If LESS than 1 day,

hrs. or

min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Home

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

Balt Md

10-NAME OF FATHER.

John Hargrave

11-BIRTHPLACE OF FATHER,
(State or Country).

Ga

12-MAIDEN NAME OF MOTHER.

Nettie

13-BIRTHPLACE OF MOTHER,
(State or Country).

Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Hargrave

(Address)

1133 Polino St

15.

Filed

107

ROBERT

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

7 2
(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Intestinal

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed)

(Coroner.)

192... (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Residential

8/7/22

20-UNDERTAKER,

ADDRESS

John Hargrave 508 Dolphin St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66644

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bessie Cohen

(a) RESIDENCE. No.

27 N. Broadway ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Jacob Cohen

6 DATE OF BIRTH (month, day, and year)

July 7/1878

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Russia

10 NAME OF FATHER

Alter Stachler

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Bessie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant
(Address)

Hospital Records

15

AUG 8 1922

ROBERT R. KRAUTER

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 6, 1922, to Aug 8, 1922

that I last saw her alive on Aug 8, 1922

and that death occurred, on the date stated above, at 8:30 Am.

The CAUSE OF DEATH* was as follows:

Pneumonia

(3 days)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris Gellman, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Rosebud

8/8 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 5th St.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient. e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Baptism
Bronchitis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66645

CERTIFICATE OF DEATH.

D 66645

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Madison Avenue ST. 11 WARD)

2-FULL NAME Amelia J. Hamilton

(a) RESIDENCE No. 1014 Madison Avenue ST. WARD

(Usual place of abode)
Length of residence in city or town where death occurred 77 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced
HUSBAND of Henry Hamilton
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6, 1845

7 AGE Years Months Days If LESS than 1 day, hrs or min.
77 1 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER ----- Harper

11 BIRTHPLACE OF FATHER (city or town) Do not know
(State or country)

12 MAIDEN NAME OF MOTHER ----- Zell

13 BIRTHPLACE OF MOTHER (city or town) Do not know
(State or country)14 Informant Miss Kate McCarthy
(Address) 1014 Madison Avenue

15 AUG 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1922, to Aug 6, 1922, that I last saw her alive on Aug 1 6, 1922, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Senility
achylia gastrica (no occult blood in stomach)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) hemorrhage from bowel, Cancer? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? occult blood for 2 mos visible blood 1 day

(Signed) J. A. Knicker M. D.

19 (Address) 1025 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park Cemetery

DATE OF BURIAL

8/8 19 22

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66646

CERTIFICATE OF DEATH.

D 66646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 Mulliken ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Arthur Milford Chittenden

(a) RESIDENCE NO.

1522 Mulliken

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 15 - 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

123

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Arthur M. Chittenden

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Attleboro, Mass.

12 MAIDEN NAME OF MOTHER

Mary E. Laupley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant

(Address)

Arthur M. Chittenden
1522 Mulliken

15

AUG 8 - 1922ROBERT H. KRAUTER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 8 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1922 to Aug 8, 1922.that I last saw him alive on Aug 7, 1922and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Exhaustion

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? NO Date ofWas there an autopsy? NO

What test confirmed diagnosis?

General DiagnosisSigned Adolph E. Eisenberg, M. D.8, 1922 (Address) 2201 E 03 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDER TAKER

ADDRESS

Baltimore CemeteryAug 10, 1922John W. Smith2008 Orleans

CASE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. PHYSICIANS should certify.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66647

CERTIFICATE OF DEATH.

113 ✓ D 66647

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3906 Philadelphia ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Viola Hutton

(a) RESIDENCE No.

3906 Philadelphia ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 6 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 2 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Harry Hutton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Anna Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Harry Hutton
3906 Philadelphia ST.

15

AUG 8 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 4, 1922, to Aug 7, 1922.that I last saw him alive on " 7, 1922.and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Fasto Enteritis(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

yesDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) A. C. Seaver M. D.Address 2601 E. Mall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Carmel Cem

20 UNDERTAKER

John Ullrich

DATE OF BURIAL

Aug 9 1922

ADDRESS

2008 Adams

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66648

CERTIFICATE OF DEATH.

D 66648

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *40. Butte Genl Hosp* ST. *24* WARD)

2. FULL NAME

(a) RESIDENCE NO. *103 E. West* ST. _____ WARD _____
(Usual place of abode)Length of residence in city or town where death occurred *38* yrs. *2* mos. *5* ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *June 30 1894*7 AGE Years *28* Months *1* Days *8* If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer *City*9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Charles Earnest*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md.*12 MAIDEN NAME OF MOTHER *Carrie Miller*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md.*14 Informant *Carrie Earnest Crist* (Address) *Annapolis Md.*15 *AUG 8 - 1922* Burial Permit *Clark*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 7* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 4*, 19*22*, to *Aug 7*, 19*22*, that I last saw him alive on *Aug 7*, 19*22*, and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

*Septicemia*CONTRIBUTORY (Secondary) *Carbuncle of face* (duration) _____ yrs. _____ mos. *3* ds.18 Where was disease contracted if not at place of death? *103 E. West St.*Did an operation precede death? *No* Date of *8/4/22*

Was there an autopsy?

What test confirmed diagnosis? *Squid Symptom*(Signed) *William B. Dallon*, M. D.8/7, 1922 (Address) *817 Port Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Mt Carmel*20 UNDERTAKER *Co B Harle* ADDRESS *115 E West St*

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66649

HEALTH DEPARTMENT—CITY OF BALTIMORE, D 66649

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hospital* ST. *2nd* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Michael McNamee*(a) RESIDENCE NO. *1508 Webster* ST. *2nd* WARD(Usual place of abode)
Length of residence in city or town where death occurred *Life* yrs. mos. ds.(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *1861*7 AGE *61* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Factory worker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Md.*
(State or country)10 NAME OF FATHER *James McNamee*11 BIRTHPLACE OF FATHER (city or town) *Ireland*
(State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Ireland*
(State or country)

14

Informant
(Address)*Bay View Hospital
Baltimore, Md.*

15

8-1922

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 5, 1922*17 I HEREBY CERTIFY, That I attended deceased from *July 10, 1922* to *August 5, 1922*.
that I last saw him alive on *August 5, 1922*and that death occurred, on the date stated above, at *12.25 p.m.*

The CAUSE OF DEATH* was as follows:

*Terminal Broncho-pneumonia*CONTRIBUTORY *Senile dementia & deterioration*
(Secondary) (duration) yrs. mos. ds. *6* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *No*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. G. Smith* M. D., 19 *Bay View Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Ave. Aug. 9, 1922

20 UNDERTAKER

ADDRESS

*Margaret C. Flynn 1414 High St.*PHYSICIANS should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66650

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-007 D 66650

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 2618 Bernard ST. 17 WARD)
FULL NAME Harry Smith
(Residence in Baltimore: No. 2618 Bernard st St.: yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M. 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH Aug 7, 1922 (Month) (Day) (Year)

7-AGE, If LESS than 1 day, yrs. mos. ds. 11 hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ooo

9-BIRTHPLACE, (State or Country) Balt city

10-NAME OF FATHER Thomas J. Smith

11-BIRTHPLACE OF FATHER (State or Country) Ind

12-MAIDEN NAME OF MOTHER Sarah E. Fair

13-BIRTHPLACE OF MOTHER (State or Country) Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas J. Smith
(Address) 2618 Bernard st

15- Robert P. Harrison,
Filed, 101. Registrar.

1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Heart disease
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) John Harrison D. (Coroner)
Aug 8, 1922 (Address) 3622 Polk
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state the MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, St Marys Hospital, Aug 9, 1922
20-UNDERTAKER ADDRESS Chenoweth Electric

Orate

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia," (merely symptomatic), "At-rophy," "Collapse," "Coma," "Convulsions," "De-bility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite dis-ease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicæmia," "PUERP-ERAL peritonitis," etc. State cause for which sur-gical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Ex-amples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homi-cide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional in-formation which may give any of the following diseases, without explanation as the sole cause of death:

<i>Abortion,</i>	<i>Hæmorrhage,</i>	<i>Meningitis,</i>	<i>Phlebitis,</i>
<i>Cellulitis,</i>	<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Pyæmia,</i>
<i>Childbirth,</i>	<i>Gastritis,</i>	<i>Necrosis,</i>	<i>Septicæmia,</i>
<i>Convulsions,</i>	<i>Erysipelas,</i>	<i>Peritonitis,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66651

CERTIFICATE OF DEATH.

D 66651

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3306 Bateman Ave. 15 WARD)

2-FULL NAME

Mrs P. Johansson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

3306 Bateman Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jun 24th 1922

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

1

6

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

13. St. Paul

10 NAME OF FATHER

John P. Johansson

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Norway

12 MAIDEN NAME OF MOTHER

Peterson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

N.Y.

14

Informant
(Address)Mrs P. Johansson
3306 Bateman Ave.

15

AUG 9 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 29, 1922, to Aug 8, 1922,
that I last saw him alive on Aug 7, 1922.

and that death occurred, on the date stated above, at 7:45 A. M.

The CAUSE OF DEATH* was as follows:

Encephalitis

Hemiplegia

Secondary aneurysm

(duration)

yrs.

mos.

10 ds.

CONTRIBUTORY ~~Hypertension~~ from ~~fatigue~~ - ~~restless~~.
(Secondary) ~~met~~

(duration)

yrs.

mos.

1 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery Aug 9th 1922

20 UNDERTAKER

ADDRESS

B. Johansson 1025 Madison Ave.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Etiology unknown
Sudden onset of
convulsions

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

2-FULL NAME

(a) RESIDENCE. No.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

1849

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

73

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant

(Address)

15

AUG 9 - 1922

ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That deceased from

that I last saw h alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

CONTRIBUTORY
(Secondary)

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Furthman, M. D.

1916 D. H. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 66653 HEALTH DEPARTMENT—CITY OF BALTIMORE

66653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 355 Calhoun ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No. 355 Calhoun ST.: 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred abt 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Oct 15 = 1841

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.81

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workRetired(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Brookerson11 BIRTHPLACE OF FATHER (city or town)
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Brookerson13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Brookerson

14

Informant
(Address)Miss Ida Schuratz
355 Calhoun St.

15

Filed

AUG 9 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/7/22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 21, 1921, to 8/7/22, 1922,that I last saw him alive on 8/7/22, 1922,and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Ch. Bronchitis
Empysem
(duration) yrs. 6 mos. ds.CONTRIBUTORY
(Secondary)Old age
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) F. M. M. M., M. D.1922 (Address) 1302 N. Federal*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Peter's Cn8/10 1922

20 UNDERTAKER

ADDRESS

Robert BrookersonCOR CALHOUN
HOLLINS
ST

PHYSICIANS should state place of death. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

66654

HEALTH DEPARTMENT--CITY OF BALTIMORE

129

66654

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 10 Jackson Ave; Parkersburg, Md 27 ST. 27 WARD)

FULL NAME Mrs. Ernestine Block

(Residence in Baltimore: No. 10 Jackson Ave; Parkersburg, Md St. 53 yrs. 4 mos. — ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH Oct. 3rd, 1844 (Month) (Day) (Year)

7-AGE 77 yrs. 10 mos. 5 ds. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

PARENTS

10-NAME OF FATHER Martin Raab

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Elizabeth Lörke

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Daughters Clara Benson (Address) 10 Jackson Ave, Parkersburg, Md

15-AUG 9 - 1922

ROBERT R. KRAUTER, Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 8th, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from January 15, 1912, to August 8th, 1922, that I saw her alive on August 5th, 1922, and that death occurred, on the date stated above, at 6:50 p.m. The CAUSE OF DEATH* was as follows: Arteriosclerosis, Chronic myocarditis, and Chronic nephritis.

(Duration) — yrs. 6 mos. 14 ds

Contributory (SECONDARY) Edema of Lungs

(Duration) — yrs. — mos. — ds.

(Signed) William G. Clepton M. D. Aug 8th, 1922 (Address) 2919 Huntingdon Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park

DATE OF BURIAL Aug 11th 1922

20-UNDERTAKER Holt & Turner Inc

ADDRESS 1442 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66655

CERTIFICATE OF DEATH.

90

D 66655

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

ST..

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

X yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

col

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Gemma Hall

6 DATE OF BIRTH (month, day, and year)

May 22, 1898

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

24

2

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer, 40

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Augusta, Ga

10 NAME OF FATHER

Jesse Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Augusta, Ga

12 MAIDEN NAME OF MOTHER

Amanda Ivory

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Augusta, Ga

14

Informant (Address)

Amanda Ivory
1032 Lexington St.

15

AUG 9 1922

ROBERT W. KRAMER,

Med. Officer, Health Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 7th 1922

17

I HEREBY CERTIFY, That I attended deceased from July 7th 1922 to Aug 7th 1922 that I last saw him on August 7th 1922 and that death occurred, on the date stated above, at 5 P m. The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary)

Pericarditis

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed)

Dr. E. Evans M. D.

19 (Address)

411 N Greene St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cem

Aug 9 1922

20 UNDERTAKER

ADDRESS

Brown & Freedland & Schroeder

157-66656 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66656

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, 17 WARD)

2-FULL NAME

Samuel Brown

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2420 Oak St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 8 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 8 - 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Georgia

12 MAIDEN NAME OF MOTHER

Rosie Norman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

AUG 9 - 1922ROBERT R. KRAUTER,Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7th 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 2nd 1922 to Aug 7th 1922 that I last saw him alive on Aug. 7th 1922 and that death occurred, on the date stated above, at 6:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute intestinal Indigestion(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Diarrhoea (not dysentery)(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Charles Harrison, M. D.

8/7, 1922 (Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel Cemetery

DATE OF BURIAL

Aug 9 1922

20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS

Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66657

66657

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. *In front of 1020 Low St.* ST. *5* WARD)

2-FULL NAME *Joseph Marshall's Margzile*

(Residence in Baltimore: No. *1020 Low St.*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Apr 18
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Single*
(Write the word.)

6-DATE OF BIRTH,

March

7

1892

(Month)

(Day)

(Year)

7-AGE,

29

YRS.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Babysitter*
(b) General nature of industry, business, or establishment in which employed (or employer). *004*

9-BIRTHPLACE, (State or Country),

Italy

PARENTS.

10-NAME OF FATHER,

Antonio Margzile

11-BIRTHPLACE OF FATHER

(State or Country),

Italy

12-MAIDEN NAME OF MOTHER

Giuseppa Margzile

13-BIRTHPLACE OF MOTHER

(State or Country),

Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Natalie Margzile*

(Address) *1020 Low St*

15-

ROBERT R. KRAUTER

Burlat Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

April 7

1912

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest and autopsy*
(Inquest, autopsy or inquiry.) and that said deceased came to *death*
on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease due to pyrexia and shock
wound in back
10 mm ad

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *W. Riley* M. D.

Apr 9 (Address) *1059 Riverside*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *see sum* In the of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Vincent's Cemetery

8.1.2

20-UNDERTAKER

ADDRESS

See 9

1735 Harford A

D 66658

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66658

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 Ething St. ST. 17 WARD)2-FULL NAME William Scott(a) RESIDENCE. No. 1713 Ething St. ST. 17 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored5 ~~Single, Married, Widowed,~~
or Divorced (write the word)married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) June 1870

7 AGE

52 Years

Months

Days

If LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workPorter(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

William Scott Jr.11 BIRTHPLACE OF FATHER (city or town)
(State or country)md

12 MAIDEN NAME OF MOTHER

Sarah Hall13 BIRTHPLACE OF MOTHER (city or town)
(State or country)md14 Informant
(Address)Marguerite Scott
1213 Ething St.

15 Filed

ROBERT R. KRAUTER,

Registrar

1922

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 19 2217 I HEREBY CERTIFY, That I attended deceased from
June 21, 19 22, to Aug 6, 19 22,
that I last saw him alive on Aug 6, 19 22,
and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chest Interstitial
nephritis
(duration) yrs. 2 mos. ds.CONTRIBUTORY
(Secondary)(duration) yrs. 2 mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Holmstrom M. D.192 (Address) 1504 McCulloch St.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Zion CemeteryAug 9 19 22

20 UNDERTAKER

ADDRESS

John H. Trading142

PHYSICIANS SHOULD
is very important. See instructions on back of certificate. Exact statement of OCCUPATION

D 66659		HEALTH DEPARTMENT—CITY OF BALTIMORE		D 66659	
1-PLACE OF DEATH City of BALTIMORE: (No. 1047 Front St. 590 Ward)				Registered No. C.....	
2-FULL NAME (Residence in Baltimore: No. 1047 Front St. 590 mos. ds.)				(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
PERSONAL AND STATISTICAL PARTICULARS.				CORONER'S CERTIFICATE OF DEATH.	
3-SEX Male	4-COLOR OR RACE Colored	5-Single, Married, Widowed, or Divorced. (Write the word.) Married	16-DATE OF DEATH Aug. 8, 1922 (Month) (Day) (Year)		
6-DATE OF BIRTH (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.		
7-AGE 63 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.			The CAUSE OF DEATH* was as follows: Myocardial Infarction		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).			CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) M. D. (Coroner.) 192 (Address)		
9-BIRTHPLACE (State or Country), Maryland			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
PARENTS.	10-NAME OF FATHER, Unknown		18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.		
	11-BIRTHPLACE OF FATHER, (State or Country), Unknown		Where was disease contracted, if not at place of death?.....		
	12-MAIDEN NAME OF MOTHER, Unknown		Former or usual residence.....		
	13-BIRTHPLACE OF MOTHER, (State or Country), Unknown		19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Swartz Cemetery Aug 9, 1922		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) May Jackson (Address) 1047 Front St.			20-UNDERTAKER, ADDRESS Mrs Robert A. E. Ashland Jr 1725		
15- AUG 9 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk					

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66660

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *12 W. Mt Vernon Place* ST. *11* WARD)2-FULL NAME *Margarette Riggs Pleasant*(a) RESIDENCE. NO. *12 W. Mt Vernon Place* ST. *1* WARD. *11*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *85* yrs. *9* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *widowed*

5a If married, widowed, or divorced

*Wife of J. Hall Pleasant*6 DATE OF BIRTH (month, day, and year) *Nov 8th 1836*7 AGE Years *85* Months *9* Days *—* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Samuel Riggs*11 BIRTHPLACE OF FATHER (city or town) *Ind.* (State or country)12 MAIDEN NAME OF MOTHER *Margaret Norris*13 BIRTHPLACE OF MOTHER (city or town) *Ind.* (State or country)14 Informant *John Pleasant* (Address) *1115 N. Charles St*15 *AUG 9 - 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 8th 1922*

17 I HEREBY CERTIFY, That I attended deceased from

, 19*12*, to *Aug. 8th 1922*that I last saw him alive on *Aug. 7th 1922*and that death occurred, on the date stated above, at *12¹⁰ A. m.*

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia occurring as a terminal infection in the course of a cerebral apoplexy with paralysis

(duration) yrs. mos. ds.

CONTRIBUTORY *Cerebral apoplexy with paralysis* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Physical Examination*(Signed) *Thos. M. Dabney*, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount Cem DATE OF BURIAL *Aug 10 1922*

20 UNDERTAKER

Henry J. Jenkins Sons & Co ADDRESS *McCulloch & Richard*

PHYSICIANS should state exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.-1-19-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66661

CERTIFICATE OF DEATH.

D 66661

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

ST.

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

AUG 9 - 1922

ROBERT R. KRAUTER,

Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from July - 26 - 1922, to August 7, 1922, that I last saw him alive on August 7, 1922, and that death occurred, on the date stated above, at 10³⁰ P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
Suppression of urine
Hypertrophied prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Newton D. Orr, M. D.

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66662

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 S Schroeder ST. 18 WARD)

2-FULL NAME

Catherine Carroll

(a) RESIDENCE NO.

117 S Schroeder

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

John Carroll

6 DATE OF BIRTH (month, day, and year)

May 4th 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

John Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Katherine Mannin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mr. Charles Carroll 117 S Schroeder St.

15

Filed

AUG 9 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1922

17

I HEREBY CERTIFY, That I attended deceased from June 1st, 1922 to Aug. 7, 1922, that I last saw her alive on Aug. 7, 1922.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical Findings.

(Signed)

J. H. Barton, M. D.

(Address)

888 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

Aug 10 1922

20 UNDERTAKER

ADDRESS

John J. Cowan & Son

401 Hollister St.

J. J. Cowan

J. J. Cowan

PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66663

CERTIFICATE OF DEATH.

REGISTERED NO. C 66663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Sheridan Ave. ST.; 27 WARD)

2-FULL NAME Mrs. Emma C. Chewworth

(Residence in Baltimore: No. 504 Sheridan Ave. St.; 61 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widow

6-DATE OF BIRTH, Apr 24, 1859 (Month) (Day) (Year)

7-AGE, 63 yrs. 3 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, retired (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Philip Wagner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Christina Meseke

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. B. Chewworth

(Address) 504 Sheridan Ave.

15-

Filed AUG 9 1922 191. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 7, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1922, to Aug 7 1922, that I saw her alive on Aug 7 1922, and that death occurred, on the date stated above, at 11:00 P.m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis Chronic Interstitial Nephritis

CONTRIBUTORY (Duration) 15 yrs. mos. ds. Cerebral Hemorrhage (Secondary)

(Signed) G. Dr. T. Bishop M. D. Aug 7, 1922 (Address) 504 Sheridan Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Upper Cross Roads Md Aug 10, 1922

20-UNDERTAKER, ADDRESS, St.

John Mitchell 1211 W. Fayette

PHYSICIANS should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 lks.

D 66664

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66664

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 N. Patterson Pl. Apt. 6 WARD)

2-FULL NAME

Mary A. Shinek

(a) RESIDENCE NO.

413 N. Patterson Pl. Apt. 6

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds.

How long in U. S., if of foreign birth? 57 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Shinek

6 DATE OF BIRTH (month, day, and year) Jan. 9th 1850

7 AGE Years 72 Months 7 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bohemia—Europe

10 NAME OF FATHER Frank Forst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia—Europe

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14

Informant (Address) W. McClelland J. Thum

15

Filed AUG 9 1922

J. W. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1922 to Aug 8, 1922, that I last saw her live on Aug 8, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Parenchymatous Nephritis
Endocarditis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) one yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Maxwell L. Mayer, M. D.

(Address) 3115 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer

DATE OF BURIAL Aug 11 1922

20 UNDERTAKER Junkler & Junkler

ADDRESS 1739 Eager

D 66665

HEALTH DEPARTMENT—CITY OF BALTIMORE D 66665

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1835 M E Henry ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Elmira Leathwood

(a) RESIDENCE. No. 1835 M E Henry ST. 19 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 30 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Info (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8-1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 5, 1922, to Aug 8, 1922

that I last saw her alive on Aug 7, 1922

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

Bronchitis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Asa L. Dressels, M. D.

8-8-1922 (Address) 2565 Fredericks Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Not Christ Church Aug 10 - 1922

20 UNDERTAKER

ADDRESS

R. B. Mappist 5156 Franklin

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 9 - 1922

D 66666

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66666

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Morrow Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1122 N. Mount St., 16 WARD)

2-FULL NAME

James Ingalls

(a) RESIDENCE NO.

none (seaman)

ST.

WARD

Maine

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maine

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

(Address)

Morrow Hosp

15

Filed

19

1122 N. Mount St.

J. E. McNamee

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8-8-1922

17

I HEREBY CERTIFY, That I attended deceased from

6-14, 1922, to 8-8-1922

that I last saw him alive on 8-7-1922

and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

no

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) Howard R. Tolson

8/8, 1922 (Address) 1325 Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Trinity Ament

8/9 1922

20 UNDERTAKER

J. L. Linton & Bro

E. Balto St.

DATE OF BURIAL

8/9 1922

ADDRESS

1127

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66667

CERTIFICATE OF DEATH.

D 66667

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Woodyard(a) RESIDENCE No. Bay View Asylum.

ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown6 DATE OF BIRTH (month, day, and year) 18627 AGE Years Months Days If LESS than 1 day, hrs. or min.
60 -- -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Westminister,
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant
(Address)Hospital Records,
Municipal Hospital.

15

F AUG 9 - 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 19 22

17

I HEREBY CERTIFY, That I attended deceased from

August 6 19 22 to August 8 19 22that I last saw her alive on August 7 19 22and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic nephritis
(duration) 20 yrs. mos. ds.CONTRIBUTORY
(Secondary)Congenital hydrocephalus
(duration) 60 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Clayton M. Neill, M. D.8/8/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Elsworth WestministerAug 11 19 22

20 UNDERTAKER

ADDRESS

H. B. Bankard & SonWestminister

PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66668

D 66668

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Garrett Hospital* ST. *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Leroy Joseph Doyle

(a) RESIDENCE NO.

339 S. Guilmore St.

ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

9

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Mc

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 28 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*9**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Leroy J. Doyle

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER

Marg E. Plateau

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

14

Informant

George H. Plateau

(Address)

339 S. Guilmore St.

15

AUG 9 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 6, 1922 to *Aug 8, 1922*that I last saw him alive on *Aug 8, 1922*and that death occurred, on the date stated above, at *4:20 P.m.*

The CAUSE OF DEATH* was as follows:

*Dysentery**viral*

(duration)

yrs.

mos.

21 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Baltimore Md.

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Lawson Hilkins

M. D.

Aug 8, 1922 (Address)*1014 St. Paul St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

DATE OF BURIAL

20 UNDERTAKER

George J. Smith

ADDRESS

Payette St.

PHYSICIANS should state Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 66669 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2509 E Preston ST., 8 WARD)

2-FULL NAME

Harry J. Barranger

(a) RESIDENCE NO.

2509 E Preston ST., WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma G. Barranger

6 DATE OF BIRTH (month, day, and year)

December 30 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

7

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer (Also please) Co N.Y.

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Louis P. Barranger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Lelia Gessons

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.Y.

14

Informant (Address)

Mrs M. J. McAndrew 2509 E Preston.

15

Filed

AUG 9 - 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1922

17

I HEREBY CERTIFY, That I attended deceased from August 4, 1922 to August 7, 1922.

that I last saw him alive on August 6, 1922.

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

CONTRIBUTORY (Secondary) (duration) yrs. 3 mos 14 ds.

Lobar Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Thymolysin

(Signed) J. H. Stevens, M. D.

8/7, 1922 (Address) 2878 Hatford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Peters

Aug 10 1922

20 UNDERTAKER

ADDRESS

E. A. Wiedefeld Jr

501 E 22

PHYSICIAN should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Julius Rawlings

(a) RESIDENCE No.

685 N. Mulberry St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

maleColoredSingle

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 22, 1880

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.42417

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Maryland

10 NAME OF FATHER

Daniel Rawlings11 BIRTHPLACE OF FATHER (city or town)
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Cornelia Moore13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Maryland

14

Informant
(Address)JOHNS HOPKINS HOSPITAL

15

AUG 9, 1922

ROBERT R. KRAUTER,

Registrar
Burial Permit No. 66670

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 14, 1922, to August 8, 1922,that I last saw him alive on August 8, 1922,and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with
Uremia(duration) yrs. 4 mos. — ds.

CONTRIBUTORY

(Secondary)

Aortic InsufficiencyMyocardial Insufficiency(duration) yrs. 10 mos. — ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death?

No Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

(Signed)

Francis R. Dienaie

M. D.

Aug 9, 1922 Address

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL

Calverton Co Md

DATE OF BURIAL

Aug 10, 1922

20 UNDERTAKER

R. C. Cross

ADDRESS

1400 McElmy

157482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66671

D 66671

CERTIFICATE OF DEATH.

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Mary Febbo.(a) RESIDENCE NO. 808 Stiles St. City.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced

~~HUSBAND of~~
~~WIFE of~~Dominic Febbo.6 DATE OF BIRTH (month, day, and year) Aug 13 19217 AGE Years Months Days 11 8 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?12 MAIDEN NAME OF MOTHER ?13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?14 JOHNS HOPKINS HOSPITALInformant
(Address) Records

15

AUG 9 1922ROBERT A. KRAUTER
Registrar

20 UNDERTAKER

Winell D. Dyfel & Co.

DATE OF BURIAL

Aug 9 1922
ADDRESS 528 W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 192217 I HEREBY CERTIFY, That I attended deceased from July 29 1922 to Aug 9 1922, that I last saw her alive on Aug 9 1922, and that death occurred, on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia(duration) yrs. mos. 2 ds.CONTRIBUTORY (Secondary) Dysentery Measles 3 days(duration) yrs. mos. 17 ds.18 Where was disease contracted if not at place of death? Dysentery and measles at home. Broncho pneumonia at J.H.H.Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) T.B. Gay, M. D.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

St Vincent

is very important. See instructions on back of certificate.

D 66672

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66672

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No. 618 Columbia an St., 22 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 618 Columbia an St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

6-DATE OF BIRTH. Don't Know (Month) (Day) (Year)

7-AGE. 69 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Brick layer

9-BIRTHPLACE, (State or Country). Balt.

10-NAME OF FATHER. Geo Smith

11-BIRTHPLACE OF FATHER, (State or Country). Don't Know

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country). 2 2 2

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F Schlick

(Address) 618 Columbia an St.

15. AUG 9 1922 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 8 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary disease of the heart

(Duration) Don't Know

CONTRIBUTORY (Secondary) Don't Know

(Signed) W. J. General M. D.

8-9 1922 (Address) 115 W. Salisbury St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Baltimore Aug 10 1922

20-UNDERTAKER, ADDRESS

Geo Lembedrol 682 W. ...

D 66673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66673

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3726 Surry Falls Pk. WARD)

2. FULL NAME

William J. Wilkinson

(a) RESIDENCE NO. 3726 Surry Falls Pk. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 0 mos. 0 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Belle U. Wilkinson

6 DATE OF BIRTH (month, day, and year)

Feb 16, 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

5

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Proof Reader

(b) General nature of industry, business, or establishment in which employed (or employer)

663

(c) Name of employer

Baltimore News

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Wm. J. Wilkinson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Virginia Savage

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Mr. Roger Lippert 3726 Surry Falls Pk.

15

Robert F. Harrison,

1922

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Apr 1, 1922, to Aug 8, 1922.

that I last saw him alive on Aug 7, 1922.

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum-bladder-prostate

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

Carcinoma of rectum-bladder-prostate

(duration) yrs. 7 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Physical

(Signed) W. S. Hubert, M. D.

Aug 12, 1922 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

LOYAL Clayton N. J.

Aug 10, 1922

20 UNDER TAKER

ADDRESS

Wm. J. Hickman 3726 Surry Falls Pk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66674

CERTIFICATE OF DEATH.

D 66674

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

Snow Memorial Hospital ST. 43 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Lane Atkinson

(a) RESIDENCE. No.

Gonzales Texas

ST.

WARD

Gonzales Texas

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 7 1872

7 AGE

50 Years

0 Months

2 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Texas

10 NAME OF FATHER

Wm. M. Atkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Mary Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Texas

14

Informant

(Address)

Henry A. Harrison
1101 N. Baltimore

15

Filed

Robert P. Harrison,

Registrar

1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 9 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 30, 1922, to Aug 9, 1922,

that I last saw him alive on Aug 9, 1922,

and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Peritonitis caused by perforation of gastric ulcer during post-operative convalescence after removal carcinoma of jaw. (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Edward M. Harriman, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Gonzales Texas Aug 10 1922

20 UNDERTAKER

ADDRESS

Henry W. Jenkins & Son Co. Inc. Culpeper

is very important. See instructions on back of certificate.

D 66675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Frank J. Cleary......

(Residence in Baltimore: No. 528 E. 23rd. St. St.; yrs., 30 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH, January 1st, 1892. (Month) (Day) (Year)

7-AGE, 30 yrs., 7 mos., 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Salesman. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, James Cleary.

11-BIRTHPLACE OF FATHER, (State or Country), Nova Scotia.

12-MAIDEN NAME OF MOTHER, Anna Meara.

13-BIRTHPLACE OF MOTHER, (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene J. Finnegan, brother-in-law.

(Address) 528 E. 23rd. St.

15-

Filed Robert L. Harrison, Registrar.

1922

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 7th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration and compound comminuted fracture of the leg.
Automobile accident.

(Duration) yrs. mos. 12 ds.

CONTRIBUTORY Septicemia. (Secondary)

(Duration) yrs. mos. 2 ds.

(Signed) Wm. H. Pennington M. D. (Coroner)

Aug. 8th 492.2 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. 12 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Brooklyn Ave. & 7th St. Brooklyn.

~~XXXXXX~~ July 25th, 1922.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral Cemetery Aug 10 1922

20-UNDERTAKER, ADDRESS,

Chas. H. Evans & Son 118 W. Mt. Royal Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66676

D 66676

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1005 S Kenwood* ST.: *4th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward Trzeciak(a) RESIDENCE. NO. *1005 S Kenwood* ST. *1* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. — mos. — ds. How long in U. S., if of foreign birth? *Life* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *2-18-22*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt Md 2189

10 NAME OF FATHER

John Trzeciak

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Victoria Bihowiec

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

John Trzeciak 1005 S Kenwood

15

Filed

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 8.* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Aug. 7*, 19 *22*, to *August 7*, 19 *22*.that I last saw him alive on *Aug. 7*, 19 *22*.and that death occurred, on the date stated above, at *8 p* m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

Enterocolitis(duration) yrs. *1* mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical Signs*(Signed) *J. B. Brown* M. D.8-8-1922 (Address) *3037 O'Donnell St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cemetery Aug 10 19 *22*

20 UNDERTAKER

ADDRESS

Stephen F. Fialkowski 1005 S Kenwood

D 66677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66677

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert F. Harrison, Registrar

1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 7, 1922, to Aug 8, 1922,

that I last saw her alive on Aug 8, 1922,

and that death occurred, on the date stated above, at 10-45 AM.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. L. Burke, M. D.

, 19 (Address) 3042 Hudson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Stanislaus Cem Aug 10 1922

20 UNDERTAKER

ADDRESS

Stephen J. Frankowski 1000 S. Howard Ave

PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66678

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 N Chapel ST.)

WARD)

2-FULL NAME Sophia Rimbach

(a) RESIDENCE. No. 1623 N. Chapel ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Albert Rimbach

6 DATE OF BIRTH (month, day, and year) May 15-1837

7 AGE Years 85 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER George Graul

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Rimbach

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant George J. Rimbach (Address) 2202 Adams St

15 Filed 19 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 1919, to Aug 8 1922

that I last saw her alive on Aug 7 1922

and that death occurred, on the date stated above, at 7:50 A. M.

The CAUSE OF DEATH* was as follows:

Bronchitis

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.

Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? General Diagnosis

(Signed) Adolph C. Eisenberg, M. D.

Sep. 1922 (Address) 2202 Adams St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Aug 10 1922

20 UNDERTAKER ADDRESS

William G. Schaeffer 1816 Monument

Burial Permit Clerk.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Mary Hospital* ST. *3* WARD)
FULL NAME *Charles Rowe*
(Residence in Baltimore: No. *800 Black & Pratt* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Male</i>	4-COLOR OR RACE <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) <i>Single</i>
6-DATE OF BIRTH,, <i>1</i> (Month) (Day) (Year)		
7-AGE, <i>71</i> yrs. <i>about</i> mos. ds.		IF LESS than 1 day,hrs. or.....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE, (State or Country), <i>Missouri</i>		
PARENTS.	10-NAME OF FATHER,	
	11-BIRTHPLACE OF FATHER (State or Country),	
	12-MAIDEN NAME OF MOTHER	
	13-BIRTHPLACE OF MOTHER (State or Country),	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Police Dept*
(Address).....

15- *Robert P. Harrison*
1922 Burial Permit Clerk.
Morgan Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July 30, 1912*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.
The CAUSE OF DEATH* was as follows:
Fract skull - small by auto accident. (Driver here)
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary).....
(Duration).....yrs.....mos.....ds.
(Signed) *W. H. H.* M. D.
(Coroner.)
Accy, 1912. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place *Shut up* In the of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
20-UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND
Commissioner Health
AUG 3 - 1922

D 66680

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 206 4 Garrison Ave. St. 70 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 206 4 Garrison Ave. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, May 15, 1912 (Month) (Day) (Year)

7-AGE, 10 yrs., 2 mos., 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, School (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Thomas Amiger

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Theresa Gavin

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Thomas Amiger (Address), 206 4 Garrison Ave.

15- Robert P. Harrison, Registrar.

1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 9, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(Duration) 1 yrs., mos., ds.

CONTRIBUTORY Inflammatory

(Signed) James M. Keaton M. D. (Coroner.)

Aug 9, 1922 (Address) 700 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, ... yrs., mos., ds. In the State, ... yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Landon Park Cemetery Aug. 11, 1922

20-UNDERTAKER, ADDRESS

William Cook 502 E. North Ave.

D 66681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 66681

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S Chapel

ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME VERONIKA BIEDRONSKI

(a) RESIDENCE NO. 613 S Chapel

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds.

How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of Frank Biedronski
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4 1875

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

49

6

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Houswork

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

10 NAME OF FATHER Louis Bialek

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Johanna Pragowski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)14 Informant Frank Biedronski
(Address) 613 S. Chapel Street

15 Robert S. Registrar

1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1920, to Aug 7 1922.

that I last saw him alive on Aug 7 1922.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam. & Laboratory

(Signed) A. F. Reis, M. D.

Aug 8 1922 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Rosary

August 10 1922

20 UNDERTAKER

JOHN M. WEBER

1803 Bank St

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assoc.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Chronic Valvular
Heart Disease*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66682

CERTIFICATE OF DEATH.

D 66682

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 St Helena Ave ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Brundrett(a) RESIDENCE. No. 321 St Helena Ave. ST. 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND
(or) WIFE ofJohn Wardel Brundrett6 DATE OF BIRTH (month, day, and year) Nov 15 - 1848

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.73824

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Chorley
England

10 NAME OF FATHER

Thomas Bolton

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Caroline Adams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

England

14

Informant Arthur A. Brundrett
(Address) 5929 Falls Rd

15

1922Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1922

17

I HEREBY CERTIFY, That I attended deceased from
Sep 21, 1921, to Aug 8, 1922,
that I last saw her alive on Aug 8, 1922.and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis, Acute suppurative(duration) yrs. 10 mos. 17 ds.CONTRIBUTORY
(Secondary)(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? Yes Date of Oct 17 - 1921Was there an autopsy? NoWhat test confirmed diagnosis? Operation(Signed) Alv Reier M. D., 19 (Address) 1 Kinship Rd. Brundlett, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Zion Cemetery Aug 11 1922

20 UNDERTAKER

Ede Roy Stapples 125 E 7th

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66683

CERTIFICATE OF DEATH.

D 66683

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3101 Windsor Ave* ST. *15* WARD)2. FULL NAME *Noa Fitzpatrick*(a) RESIDENCE NO. *3101 Windsor* ST. *15* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *don't know*7 AGE *66* Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Bernard Fitzpatrick*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Julia Mahan*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *Margaret Kane 3101 Windsor*

15

1922 *Robert F. Harrison,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 7 1922*

17

HEREBY CERTIFY, That I attended deceased from *March 6, 1922* to *Aug 7, 1922* that I last saw her alive on *Aug 7, 1922* and that death occurred, on the date stated above, at *7.20 P. m.*

The CAUSE OF DEATH was as follows:

*Cerebral Hemorrhage slow flow; repeated 6-6-22 - Aug 7-22*CONTRIBUTORY (Secondary) *Cervical glandular carcinoma*18 Where was disease contracted if not at place of death? *Not known*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Cous. Dr. M. D.*(Signed) *Edgar S. Parker, M. D.*, 19 (Address) *3125 W. North Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Cem.**Aug 10 1922*

20 UNDERTAKER

ADDRESS

*Margaret S. Flynn**1422 Light St.*

D 66684 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3315-Barday ST., 17 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

3315-Barday ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Married

5a If married, widowed, or divorced

HUSBAND (or) WIFE of

Abraham Thompson

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

AUG 10 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1922, to Aug 8th, 1922, that I last saw her alive on Aug 7th, 1922, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. L. Gouly, M. D.

19 (Address) 4218 Harbor Road City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Laurel Cemetery Aug 10 1922 George J. Reith 735 Harbor Rd.

PHYSICIANS should state Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

D 66685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66685

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST. 17 WARD

2-FULL NAME

(a) RESIDENCE. NO.

ST. 17th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

AUG 10 1922 ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1922

17 I HEREBY CERTIFY, That I attended deceased from
Aug 1 - 1922, to Aug 7, 1922,
that I last saw her alive on Aug 5, 1922,
and that death occurred, on the date stated above, at 8:45 A. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hughes M. D.

Aug 7, 1922 (Address) 1413 E. Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cem Aug 10 1922

20 UNDERTAKER

Daniel E. E. & Co.

PHYSICIANS should state
DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66686

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital

ST.: V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Temperance Isabelle Woernlein

(a) RESIDENCE. No. 9 S. Register

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female	4 COLOR OR RACE white	5 Single, Married, Widowed, or Divorced (write the word) married
-----------------	--------------------------	---

5a If married, widowed, or divorced
-HUSBAND- of
(or) WIFE of Charles Woernlein

6 DATE OF BIRTH (month, day, and year) Aug. 1, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

10 NAME OF FATHER Henry Bollins

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country) Unknown14 Informant Charles Woernlein
(Address) 9 S. Register St.

15 Filed _____, 19 _____

AUG 10 1922

ROBERT R. Knepper Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9, 1922

17

I HEREBY CERTIFY, That I attended deceased from

8/2/22, to 8/9/22, 1922

that I last saw him live on 8/9/22, 1922

and that death occurred, on the date stated above, at 5:00 am

The CAUSE OF DEATH* was as follows:

Acute Cordia Diff
Pulmonary Disease

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Obstruction (duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? No knowledge

Did an operation precede death? No Date of 8/2/22

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symp

(Signed) J. A. [Signature] M. D.

, 19 (Address) 1107 W. [Address]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel Cemetery

811.22 19

20 UNDERTAKER

ADDRESS

H. E. Hughes

424 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 2504 Chelsea Ter.

FULL NAME William F. Enis

(Residence in Baltimore: No. 2504 Chelsea Terrace

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 13, 1880

7-AGE, 41 yrs. 10 mos. 26 ds.

IF LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Fire Business
(b) General nature of industry, business, or establishment in which employed (or employer). Self

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, Adolph Enis

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Ella Kaufholz

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Gladys Enis

(Address) 2504 Chelsea Ter.

15-

Filed

AUG 10 1922

ROBERT R. KREUTER, Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 8, 1912

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Gas (Duration) 1 yr. 10 mos. 26 ds.

CONTRIBUTORY (Secondary) Apoplexy

(Signed) Geo. Holliman (Coroner.) 1912 (Address) 1433 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, London Park Cem.

DATE OF BURIAL, 8/10/12

20-UNDERTAKER, Wm. J. Kitchner

ADDRESS, 1433 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.

WARD)

2-FULL NAME

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

5/24/1922, to Aug 6, 1922,

that I last saw him alive on Aug 6, 1922,

and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66689

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Higginth ST., 9 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

73 yrs.

4 mos.

1 ds.

How long in U. S., if of foreign birth?

(If non-resident, give city or town and State)

7 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Widow of Mr. A. Noppenger

6 DATE OF BIRTH (month, day, and year)

Apr. 7, 1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73

4

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Mr. Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mrs. Kuen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md. Kuen

14

Informant

(Address)

Mrs. Noppenger

15

Filed

AUG 10 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1922, to Aug. 8, 1922.

that I last saw him alive on Aug. 8, 1922.

and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

8/9/22

19 (Address)

321 E 21st

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

Aug. 11, 1922

20 UNDERTAKER

ADDRESS

Henry Horck Sr.

1301 E. Eager

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66691

CERTIFICATE OF DEATH.

Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. 913 Fell St. St. 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 913 Fell St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-Single, Married, Widowed, or Divorced. (Write the word.)

Married

6-DATE OF BIRTH.

Unknown

(Month) (Day) (Year)

7-AGE.

46

Yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

Russia, Poland

10-NAME OF FATHER.

Victor Balcerowicz

11-BIRTHPLACE OF FATHER.

(State or Country).

Russia, Pol

12-MAIDEN NAME OF MOTHER.

Unknown

13-BIRTHPLACE OF MOTHER.

(State or Country).

Russia, Pol

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Milton Balcerowicz

(Address)

913 Fell St.

15-

AUG 10 1922

FILE

192

ROBERT R. KRAUTER,

Burial Permit Officer.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug 8

1922

17-

I HEREBY CERTIFY That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

find that said deceased came to

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. R. Horton

1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Cross

8/11 1922

20-UNDERTAKER

ADDRESS

William F. Powell

D 66691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 66691

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Colgate Creek St. Helena* WARD)2-FULL NAME *Clara Hester Wood*(a) RESIDENCE. NO. *Colgate Creek St. Helena* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

Now long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Benjamin H. Wood*6 DATE OF BIRTH (month, day, and year) *June 24-1863*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*59**1**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Paris*
(State or country) *Va.*10 NAME OF FATHER *Lancelot Wilson*11 BIRTHPLACE OF FATHER (city or town) *Winchester*(State or country) *Va.*12 MAIDEN NAME OF MOTHER *Elizabeth M. Bride*13 BIRTHPLACE OF MOTHER (city or town) *Charleston*(State or country) *Va.*

14

Informant *Edward H. Wood*(Address) *321 Baltimore Ave*

15

Filed

, 19

AUG 10 1922

ROBERT P. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 9* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from
July 25, 19*22*, to *Aug 9*, 19*22*,
that I last saw him alive on *Aug 8*, 19*22*,and that death occurred, on the date stated above, at *5 A. M.*

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease(duration) *4* yrs. *7* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Asst. Reier*, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cock Lane *Aug 12* 19*22*

20 UNDERTAKER

ADDRESS

Wm. Cork *Rt 1 G Mc*

157611, HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

D 66692

1. PLACE OF DEATH

CITY OF BALTIMORE: (Non-residents, give name of hospital, etc., and ward) *JOHNS HOPKINS HOSPITAL, 70*2. FULL NAME *Hellie M. Cammon.*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2828 Frederick Ave.*
(Usual place of abode)

WARD

Length of residence in city or town where death occurred

Unknown

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Helen M. Cammon (mother)*6 DATE OF BIRTH (month, day, and year) *June 6, 1922*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
2 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

1922

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 9 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 5, 1922* to *Aug 9, 1922*.and that death occurred, on the date stated above, at *Aug 9 1922*.The CAUSE OF DEATH* was as follows: *2:00 A.M.**Prematurity*

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Chas. H. Henson* M. D.Aug 9, 1922 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Landon Park Ave Aug. 10, 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook 1003 N. Baltimore St.

TION is very important. See instructions on back of certificates. EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION.

D 66693

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66693

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 S Bond ST., 3 WARD)

2-FULL NAME

Florence Pasz Kewicz

(a) RESIDENCE NO.

734 S Bond ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 7-21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

93

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

Walter Pasz Kewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

May Sobrostan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Walter Pasz Kewicz
734 S Bond

15

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/10 19 22

17

I HEREBY CERTIFY, That I attended deceased from

8/6, 19 22, to 8/9, 19 22.that I last saw him alive on 8/9, 19 22.and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

His wife & Yester-Eaten(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Heart failure & infection(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Sym & symptoms(Signed) W A Harrison, M. D.19, 19 22 (Address) 16238 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Holy Rosary8/11 19 22

20 UNDERTAKER

ADDRESS

Wm Frankowski 1611 Eastern

1922

Burial Permit Clerk.

PHYSICIAN should state Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

157560
D 66694

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66694

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL, ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Roberta Mills

(a) RESIDENCE NO.

16 Lake Ave, Middletown, New York

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mrs. May Le Fever (sister)

6 DATE OF BIRTH (month, day, and year)

May 21st

7 AGE

Years

Months

Days

54

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H. M.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

New York

10 NAME OF FATHER

George F. Acosta

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

New York

12 MAIDEN NAME OF MOTHER

Mary Carpenter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

New York

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 10 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 3, 19 22, to Aug 10, 19 22,

that I last saw her alive on

Aug 10, 19 22,

and that death occurred, on the date stated above, at

11 55 A m.

The CAUSE OF DEATH* was as follows:

Brain tumor - right parietal glioma

symptoms about

(duration)

1 yr.

mos.

ds.

CONTRIBUTORY (Secondary)

Operation followed by

hypertension

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of Aug. 8

Was there an autopsy? No

What test confirmed diagnosis?

Specimen of Tumor

(Signed)

F. L. Pinchot, M. D.

1922 (Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOV.

Rockaway

DATE OF BURIAL

Aug 10 19 22

20 UNDERTAKER

H. C. Hughes

ADDRESS

14 Rockaway

66695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D 66695

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Argyle Ave. ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Calser(a) RESIDENCE No. 902 Argyle Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.4 COLOR OR RACE Black5 Single, Married, Widowed, or Divorced (write the word) S.5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) Nov. 19-1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 8 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work food

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto md.9 BIRTHPLACE (city or town) (State or country) Balto md.10 NAME OF FATHER Louis Calser11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto12 MAIDEN NAME OF MOTHER Louisa Hawkins13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14

Informant (Address) Mother Louis Calser
902 Argyle Ave

15

AUG 11 1922

HUBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-9- 19 22

17

I HEREBY CERTIFY, That I attended deceased from 8-8- 19 22, to 8-9- 19 22,that I last saw her alive on 8-8- 19 22and that death occurred, on the date stated above, at 4:30 P.m.

The CAUSE OF DEATH* was as follows:

malnutrition(duration) yrs. 6 mos. ds.CONTRIBUTORY (Secondary) myocardial degeneration(duration) yrs. 2 mos. ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical, + history(Signed) Victor Richards M. D., 19 (Address) 2918 Brighton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt Auburn Burial Aug 11 1922

20 UNDERTAKER

Daniel Easton Boon

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*No gastro enteritis.
Child weak since
birth. Probably
congenital debility.*

D 66696

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2611 Fair Ave ST. 1 WARD)

2-FULL NAME

Nopiech Widro

(a) RESIDENCE NO.

2611 Fair Ave

ST.

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

60 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMarried

6 DATE OF BIRTH (month, day, and year)

Sept. 2, 1853

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.681020

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Latner

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Poland

10 NAME OF FATHER

Joseph Wydr11 BIRTHPLACE OF FATHER (city or town)
(State or country)Poland

12 MAIDEN NAME OF MOTHER

Not Known13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Poland

14

Informant
(Address)Agnes Wydr
2611 Fair Ave

15

Filed

11 1922ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1922

17

I HEREBY CERTIFY, That I attended deceased from
July 10, 1922, to August 9, 1922,
that I last saw him alive on August 9, 1922.and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration)

10 monthsCONTRIBUTORY
(Secondary)

(duration)

1 yrs. 0 mos. 0 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Frank J. Samoylik, M. D.

8/10, 1922 Address)

2431 Fair Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Stanislaus Cem Aug 12 1922

20 UNDERTAKER

ADDRESS

Stephen J. Fialkowski 1000 S. Kenwood

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66697

CERTIFICATE OF DEATH.

X 119

D 66697

1-PLACE OF DEATH *Church Home and Infirmary*

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *126 N. Broadway* ST. *6* WARD)

2-FULL NAME *Frances Thompson Powell*

(a) RESIDENCE NO. *Church Home Infirmary* ST. *Louisville Ky.* WARD *Louisville Ky.*
(Usual place of abode)

Length of residence in city or town where death occurred *0* yrs. *0* mos. *8* ds. How long in U. S., if of foreign birth? *44* yrs. *3* mos. *3* ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mr. Henry J. Powell*

6 DATE OF BIRTH (month, day, and year) *May 7-1878*

7 AGE Years *44* Months *3* Days *3* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer) *none*

(c) Name of employer *none*

9 BIRTHPLACE (city or town) *Cadiz* (State or country) *Kentucky*

10 NAME OF FATHER *Mose S. Thompson*

11 BIRTHPLACE OF FATHER (city or town) *Cadiz* (State or country) *Kentucky*

12 MAIDEN NAME OF MOTHER *Nannie Ginter*

13 BIRTHPLACE OF MOTHER (city or town) *Cadiz* (State or country) *Kentucky*

14 Informant *Mr. Henry J. Powell (husband)* (Address) *Louisville Ky.*

15 Filed *AUG 11 1922* ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 10 - 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Aug. 7*, 1922, to *Aug. 10*, 1922, that I last saw her alive on *Aug. 10*, 1922, and that death occurred, on the date stated above, at *4⁰⁰ P. m.*

The CAUSE OF DEATH* was as follows:

Acidosis - Following operation

(duration) yrs. mos. *4* ds.

CONTRIBUTORY *Liver w. abs. & hemorrhoids* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Aug. 3-1922*

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical Methods*

(Signed) *Richard G. Cobbentz*, M. D.

, 19 (Address) *Church Home and Infirmary*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOORE

DATE OF BURIAL

Louisville - Ky. Aug 11 1922

20 UNDERTAKER ADDRESS

Stewart-McCowan Company 108 N. North St. W. F. Warden

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66698

CERTIFICATE OF DEATH.

129 D 66698

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N. Bond. ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sedonia Stewart

(a) RESIDENCE. NO.

604 N. Bond

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Widowed.

5a If married, widowed, or divorced

(or) WIFE of

James P. Stewart

6 DATE OF BIRTH (month, day, and year)

April 24, 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

3

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Mr. Wm. H. Walker 604 N. Bond St. (same as decd)

15

Filed AUG 11 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/9/1922

17

I HEREBY CERTIFY, That I attended deceased from

July 31, 1922, to 8/9, 1922

that I last saw her alive on 8/9, 1922,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Unknown

Did an operation precede death? no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Physical & Lab.

(Signed) R. J. Young, M. D.

, 19 (Address) 429 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery Aug 13 1922

20 UNDERTAKER

Edward Bayon

ADDRESS 1631

Orleans

This is very important. See instructions on back of certificates. Exact statement of OCCUPA- should state

D 66699

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66699

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard and Thoms sts.

ST.:

WARD)

2-FULL NAME

Dr James M Corkran

(a) RESIDENCE. NO.

Centerville, Md.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

7 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

Mrs. J. M. Corkran

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Thos. Corkran

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Hester Wright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Mrs. J. M. Corkran. Centerville, Md.

15

Filed

19

AUG 11 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8-11

1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 2

1922

to Aug. 11

1922

that I last saw him alive on

Aug 11

1922

and that death occurred, on the date stated above, at

450 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration)

yrs.

4?

mos.

ds.

CONTRIBUTORY (Secondary)

Broncho pneumonia + renal

apoplexy

(duration)

yrs.

6

mos.

ds.

18 Where was disease contracted

Home

if not at place of death?

Did an operation precede death?

yes

Date of

8/5/22

Was there an autopsy?

no

What test confirmed diagnosis?

operative + clinical findings

(Signed)

J. H. B. M. D.

Sp. 1922 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Centerville Md

DATE OF BURIAL

20 UNDERTAKER

Henry W. Jenkins & Sons

ADDRESS

McCallish Orchard

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66700

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 McCulloh ST. 17th WARD)

2-FULL NAME William Johnson

(a) RESIDENCE. NO. 1116 McCulloh ST. 17th WARD.

(Usual place of abode)

about 20 yrs.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

M

C

Married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Maggie Johnson

6 DATE OF BIRTH (month, day, and year) Nov. 18, 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

9

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

Porter

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) Richmond Va.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14

Informant

Dr. H. White

(Address)

1118 Druid Hill Ave.

15

Filed

19

AUG 11 1922 ROBERT R. KRASTNER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/8/22 19

17

I HEREBY CERTIFY, That I attended deceased from

May 29, 1922, to August 8, 1922

that I last saw him alive on Aug. 8, 1922

and that death occurred, on the date stated above, at 8:45 P.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY Uremic Coma (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? XXXXX

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery

Aug. 11, 1922

20 UNDERTAKER

ADDRESS

Robert L. Parham

St. 220 Hamburg

HEALTH DEPARTMENT—CITY OF BALTIMORE

66701

CERTIFICATE OF DEATH.

113 D 66701
REGISTERED NO. C1-PLACE OF DEATH *750*CITY OF BALTIMORE: (No. *750 Bradley*ST.; *17* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Herman Williams*(Residence in Baltimore: No. *750 Bradley St*St.; *XX* yrs., *6* mos. *14* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored~~SINGLE,~~
~~MARRIED,~~
~~WIDOWED,~~
~~OR DIVORCED,~~
(Write the word.)
Single

6-DATE OF BIRTH.

January 23, 1922
(Month) (Day) (Year)

7-AGE,

XX yrs., *6* mos., *14* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*None*9-BIRTHPLACE,
(State or Country),*510 Green St, Baltimore Md*

10-NAME OF FATHER,

*Warner Williams*11-BIRTHPLACE OF FATHER
(State or Country),*Fredrick Co., Md*

12-MAIDEN NAME OF MOTHER

*Alice Myers*13-BIRTHPLACE OF MOTHER
(State or Country),*Carroll Co., Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mother*(Address) *750 Bradley St*

15-

Filed *AUG 11 1922*ROBERT M. JOHNSON,
Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 9th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 8, 1922, to Aug 8, 1922*that I saw him alive on *Aug 8, 1922*and that death occurred, on the date stated above, at *3¹⁵ A. m.*

The CAUSE OF DEATH* was as follows:

Indigestion Intestinal(Duration) *XX* yrs., *6* mos., *14* ds.CONTRIBUTORY
(Secondary)(Duration) *XX* yrs., *6* mos., *14* ds.(Signed) *John H. Aubrey* M. D.Address *1629 St Paul St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *XX* yrs., *XV* mos., *21* ds. In the *XX* yrs., *6* mos., *14* ds.Where was disease contracted, *500 Green St.*
if not at place of death?Former or usual residence *750 Bradley St.*

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn

DATE OF BURIAL,

Aug 11, 1922

20-UNDERTAKER

*David Easton*ADDRESS *916**Be an*

Please see instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

66702

CERTIFICATE OF DEATH.

REGISTERED NO. C

66702

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1409 Patapiscus* ST.; *73* WARD)2-FULL NAME *Sarah Hooper*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1409 Patapiscus St.* St.; *71* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widowed*

6-DATE OF BIRTH,

*May**30*, 18*51*

(Month)

(Day)

(Year)

7-AGE,

71 yrs. *2* mos. *11* ds.

If LESS than 1 day,

.... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *John Schmick*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *Dorothy Werner*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Mary L. Byers*(Address) *135 N. Calverton*

15-

*ROBERT J. JONES*Filed *AUG 11 1922**101**Bureau*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH,

*August**10*, 19*22*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Aug 1st* 19*22*, to *Aug 9th* 19*22*that I saw her alive on *Aug 9th* 19*22*and that death occurred, on the date stated above, at *5A* m.

The CAUSE OF DEATH* was as follows:

*Chronic Interstitial**nephritis*(Duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. mos. ds.(Signed) *H. C. Carver**Aug 10, 1922* (Address) *412 N. Calverton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore County*DATE OF BURIAL, *Aug 12, 1922*20-UNDERTAKER *E. J. Manning & Son - 1938 E. Defayeth St*

ADDRESS

D 66703

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 Falls Road, 13 ST., 13 WARD)

2-FULL NAME

(a) RESIDENCE, NO. 3503 Falls Road, ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar, 30/1899

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

4

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mull Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

Cotton Mills

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

John C. Housman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore City

12 MAIDEN NAME OF MOTHER

Margaret P. Parrish

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore City

14

Informant (Address)

Mrs. Smith 3503 Falls Road

15

Filed

AUG 11 1922

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1st, 1922, to August 9, 1922, that I last saw her alive on August 8, 1922, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Davis, M. D.

860 W 38th ST

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Lorraine Cemetery Aug 11, 1922

20 UNDERTAKER ADDRESS

W. S. Marshall 3503 Falls Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66704

CERTIFICATE OF DEATH.

REGISTERED NO.

D 66704

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2727 Huntington Ave. 17 WARD)

2-FULL NAME

Mary Ellen Smith

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

12727 Huntington Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a ~~Married~~, widowed, or divorcedHUSBAND of
(or) WIFE of

Eli Smith

6 DATE OF BIRTH (month, day, and year)

Sept 22 1847

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

74

10

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

John England

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Eliza Darby

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant
(Address)Miss Manner Smith
3727 Huntington Ave.

15

Filed

. 19

AUG 11 1922

ROBERT R. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1922

17

I HEREBY CERTIFY, That I attended deceased from
May 10th, 1922, to Aug 9th, 1922,
that I last saw her alive on Aug 8th, 1922,
and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

of Indefinite duration yrs. 18 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination
of urinary sediment
(Signed) A. S. Norment M. D.

8.10.1922 (Address) 8147 Chestnut Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Rouben Park Aug 17th 19

20 UNDERTAKER

ADDRESS

A. S. Marshall 3337 1/2 Ref

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66705

CERTIFICATE OF DEATH.

90 D 66705

PLACE OF DEATH

CITY OF BALTIMORE (No. 721 W 36 St ST. 13 WARD)

FULL NAME

(Residence in Baltimore: No. 721 W 36 St

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

June 28, 1862
(Month) (Day) (Year)

7-AGE

60 yrs. 1 mos. 10 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Labor
040

9-BIRTHPLACE, (State or Country),

Baltimore Co

10-NAME OF FATHER,

Henry F Baker

11-BIRTHPLACE OF FATHER, (State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Betty A Bull

13-BIRTHPLACE OF MOTHER, (State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm L Baker
721 W 36 St
(Address)

15-

Filed AUG 11 1922

ROBERT R. KRAUTER,
Burial Permit Clerk,
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 18, 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest (Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, au-

opsy and that said deceased came to death (death, topsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary disease
of heart
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Morrison M. D.
(Coroner.)

Aug 18, 1922 (Address) 322 Roland

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Pleasant Aug 17, 22

20-UNDERTAKER

AS Marshall 3539 Full Rd
ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66706

66706

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

ROBERT T. KRAUSE

Registrar

AUG 11 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 12, 1922, to Aug 10, 1922,

that I last saw him alive on Aug 10, 1922,

and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Childbirth accompanied by
lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. B. Rowland, M. D.

Address 3548 Chesapeake Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys St Aug 12 1922

Address 3539 Cal Rd

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Pneumonia prior to delivery. Premature delivery & Pneumonia caused premature birth.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66707

REGISTERED NO. C

1-PLACE OF DEATH *St Washington*
CITY OF BALTIMORE (NO. *27* ST. *27* WARD)
2-FULL NAME *Albert C. Jones*
(Residence in Baltimore: No. *Penick Road & Krebs one* St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *M.*
4-COLOR OR RACE, *W.*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) *Single*
6-DATE OF BIRTH, *Nov 19 1907*
(Month) (Day) (Year)
7-AGE, *14* yrs. *8* mos. *21* ds.
If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Helper in*
(b) General nature of industry, business, or establishment in which employed (or employer), *Ja. Hogan*

9-BIRTHPLACE, (State or Country), *Ireland*
10-NAME OF FATHER, *John Jones*
11-BIRTHPLACE OF FATHER (State or Country), *Ireland*
12-M maiden NAME OF MOTHER, *Margaret Rudderill*
13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *John Jones*
(Address) *St Washington*

15-
FILED *AUG 11 1922*
ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 9 1922*
(Month) (Day) (Year)
17-I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by and on the day stated above.
The CAUSE OF DEATH* was as follows:
Injuries received from automobile accident
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(Signed) *John H. Harrison* M. D.
(Coroner.)
(Address) *763 2nd St*
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, the (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, *St Marys Hampton*
DATE OF BURIAL, *Aug 11 1922*
20-UNDERTAKER, *Cohenoweth Son & Co*
ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66708

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 426 S. Payson ST.: 70 WARD)

2-FULL NAME

(a) RESIDENCE. No. 426 S. Payson ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27-1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Ind

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Ind

PARENTS

14 Informant (Address)

15

Filed

AUG 11 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1922, to Aug 9, 1922.

that I last saw him alive on Aug 9, 1922.

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) yrs. mos. 3 hrs

CONTRIBUTORY (Secondary)

(duration) yrs. mos. Life ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones M. D.

10, 1922 (Address) 222 August St

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Melville Cemetery (Elkridge, Md.) Aug 11 1922

20 UNDERTAKER

ADDRESS

George L. Schwab 2101 Eudora Ave

This certificate is to be filled out by the physician who attended the deceased, or by the coroner, or by the registrar, or by the undertaker, or by the person who has the body in his possession. It is to be filled out in full, and the information given is to be true and correct. It is to be filled out in full, and the information given is to be true and correct. It is to be filled out in full, and the information given is to be true and correct.

66709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *127 E Gitting*ST., *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Arthur R. Pudlin*(a) RESIDENCE No. *127 E Gitting*ST., *24* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

August 18, 1911

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*11**23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Samuel Pudlin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New York

12 MAIDEN NAME OF MOTHER

Elizabeth Buckner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

Samuel Pudlin, 127 E Gitting St

15

AUG 11 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 10* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 6*, 19*22*, to *Aug 10*, 19*22*, that I last saw him alive on *Aug 10*, 19*22*, and that death occurred, on the date stated above, at *5:30 P m.*

The CAUSE OF DEATH* was as follows:

Gastroenteritis

(duration)

yrs.

mos

ds. *5*

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds. *2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *✓*

(Signed)

H. E. Buxton

M. D.

(Address)

301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Cross A.C.C.**8-11* 19 *22*

20 UNDERTAKER

ADDRESS

*E. B. Harber**115 E West St*

156317
D 66710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69 D 66710

1. PLACE OF DEATH

CITY OF BALTIMORE: (NOVINS HOSPITAL ST. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME James Pass.

(a) RESIDENCE NO. 412 S. Washington St. City WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single.

(a) If married, widowed, or divorced

HUSBAND of

or WIFE of Nellie Pass (Mother).

6 DATE OF BIRTH (month, day, and year) May 8, 1903.

7 AGE 13 Years 3 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland. (State or country)

10 NAME OF FATHER Joseph Pass.

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Nellie Goryto

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed 11 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1922, to Aug 10, 1922.

that I last saw him alive on Aug 10, 1922.

and that death occurred, on the date stated above, at 12:50 P.M.

The CAUSE OF DEATH* was as follows:

Purpura hemorrhagica

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 412 S. Washington St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. C. Cullen, M. D.

, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

1404 Rosary Aug 14 1922

20 UNDERTAKER John M. Weber 1843 Bank ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66711

CERTIFICATE OF DEATH.

113 D 66711
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S Wolfe ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

white

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

19

AUG 11 1922

ROBERT R. KRAJCIK

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 9 1922 to Aug 10 1922

that I last saw him alive on Aug 7 1922

and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Stille M. D.

, 19 (Address) 1137 S Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Holy Rosary

Aug 12 1922

20 UNDERTAKER

ADDRESS

John A. Weber 1803 Bank

PHYSICIANS should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

PHYSICIANS should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

66712

HEALTH DEPARTMENT—CITY OF BALTIMORE

164 D 66712

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home & Infirmary*
CITY OF BALTIMORE: (No. *Broadway* ST., *4* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Sarah Virginia Brown*
(a) RESIDENCE NO. *Rochambeau Apts.* ST., *Ches.* WARD
(Usual place of abode)
Length of residence in city or town where death occurred *28* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*
5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Ezra J. Brown*
6 DATE OF BIRTH (month, day, and year) *March 22, 1846*
7 AGE Years *76* Months *8* Days *18* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *retired*
(b) General nature of industry, business, or establishment in which employed (or employer) *off*
(c) Name of employer

9 BIRTHPLACE (city or town) *New York*
(State or country)

10 NAME OF FATHER *Henry Burgoyne*

11 BIRTHPLACE OF FATHER (city or town) *S. C.*
(State or country)

12 MAIDEN NAME OF MOTHER *Rossiter*

13 BIRTHPLACE OF MOTHER (city or town) *N. Y.*
(State or country)

14 Informant *Maurice K. Russell*
(Address) *2221 Pennsylvania St.*

15 AUG 11 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) *Aug 9 1922*
17 I HEREBY CERTIFY, That I attended deceased from *June 21st*, 1922, to *Aug 9th*, 1922, that I last saw her alive on *Aug 9th*, 1922, and that death occurred, on the date stated above, at *6:15 P. M.*
The CAUSE OF DEATH* was as follows: *Senility*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frank B. Rice*, M. D.

, 19 (Address) *Church Home & Inf.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Louisa Park Aug. 11 1922*

20 UNDERTAKER *Chas. O. Mitchell* ADDRESS *1201 W. Fayette St.*

D 66713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66713

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Senior Hospital* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *2748 Harlem Ave* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*6-DATE OF BIRTH, *July 18* 19*24* (Month) (Day) (Year)7-AGE, *28* yrs. *5* mos. *21* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *clerk* (b) General nature of industry, business, or establishment in which employed (or employer), *off*9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *James Smith*11-BIRTHPLACE OF FATHER, (State or Country), *Maryland*12-MAIDEN NAME OF MOTHER, *Mary E. Tucker*13-BIRTHPLACE OF MOTHER, (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary E. Smith*(Address) *2748 Harlem Ave*

15- AUG 11 1922 ROBERT R. KRAUTER,

Filed 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 9* 192*2* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* find that said deceased came to *his* death (Inquest, autopsy or inquiry) on the day stated above.The CAUSE OF DEATH* was as follows: *Fracture of Skull (Compound) fall from porch 20 feet while in Electric Convulsion accident* (Duration) yrs. mos. ds.CONTRIBUTORY *Fracture* (Secondary) *Fracture* (Duration) yrs. mos. ds.(Signed) *John M. Kenyon* M. D. (Coroner.) *Aug 10* 1922 (Address) *700 E. Chase St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, *Franklin Senior Hospital* In the of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

*2748 Harlem Ave*Former or usual residence, *2748 Harlem Ave*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Oak Lawn *Aug 12* 1922

20-UNDERTAKER, ADDRESS

Joseph Super *1600 North Ave*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66714

D 66714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto Gen Hosp* ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Maie Reynolds

(a) RESIDENCE NO.

Cherry Hill Westport Md

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

George D. Reynolds

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

23

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George W. Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Metzger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

George D. Reynolds Cherry Hill Md.

15

Registrar

*ROBERT R. KRAUTER,**AUG 11 1922**Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Aug 5, 1922, to Aug 10, 1922.*that I last saw her alive on *Aug 10, 1922*and that death occurred, on the date stated above, at *3:30 P.M.*

The CAUSE OF DEATH* was as follows:

Typhoid fever(duration) yrs. mos. *21* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Cherry Hill Westport Md.*Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

A. F. Riss, M. D.*Aug 10, 1922* (Address)*24 S. Broadway*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Bernard

DATE OF BURIAL

Aug 12 1922

20 UNDERTAKER

Wendell Dippel Son

ADDRESS

323

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66715 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 66715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *✓* yrs. *21* mos. *21* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Maggie Newton*6 DATE OF BIRTH (month, day, and year) *Mar 4 1864*7 AGE Years *58* Months *5* Days *7* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Farmer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *John E. Newton*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Ellen Mary Broad*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*14 Informant *Mrs. Maggie E. Newton* (Address) *Kennethville Md.*15 Filed *Aug 11 1922* ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 11 1922*17 I HEREBY CERTIFY, That I attended deceased from *July 22 1922* to *Aug 10 1922*, that I last saw him alive on *Aug 11 1922*and that death occurred, on the date stated above, at *3:30 a.m.*

The CAUSE OF DEATH* was as follows:

*Carcinoma rectum
+ Lower sigmoid*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *Peritonitis + Colic*(duration) yrs. mos. ds. *15*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *7-21-22*

Was there an autopsy?

What test confirmed diagnosis? *Operative*(Signed) *J. S. Rogers* M. D.(Address) *Mary Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *Galena Md (Via Betterton)* DATE OF BURIAL *Aug 11 1922*20 UNDERTAKER *John F. Denny* ADDRESS *715 Light St*

PHYSICIANS should state Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66716

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *409 Mc Allister* ST.: *12* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *409 Mc Allister St* St.: *10* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*Negro*5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

March 10, *1862*
(Month) (Day) (Year)

7-AGE,

*60*If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Domestic*9-BIRTHPLACE,
(State or Country)*St Michael Maryland*

10-NAME OF FATHER,

*Unknown*11-BIRTHPLACE OF FATHER
(State or Country),*Unknown*

12-MAIDEN NAME OF MOTHER

*Unknown*13-BIRTHPLACE OF MOTHER
(State or Country),*Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rebecca Cohen*(Address) *409 Mc Allister St*

15-

2261 11 304

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 9, *1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 8 1922, to *Aug 9 1922*,that I saw her alive on *Aug 8 1922*and that death occurred, on the date stated above, at *9:30 a.m.*

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *Harry E. ...* M. D.*Aug 10, 1922* (Address) *1601 S. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel Cemetery

DATE OF BURIAL,

Aug 12, 1922

20-UNDERTAKER

Mrs. Elias St. Bailey

ADDRESS

421 Jefferson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66717

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1628 McElderry* ST.: *7* WARD)

2-FULL NAME

Gilmore J. Pasterfield(a) RESIDENCE. NO. *2628 McElderry St.* ST. *7* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 5/22

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.*6.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*City*

10 NAME OF FATHER

*Jos. W. Pasterfield*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Md*

12 MAIDEN NAME OF MOTHER

*Catherine Hale*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Md.*

14

Informant
(Address)*Jos. W. Pasterfield*
2628 McElderry

15

AUG 11 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 11/22

17

I HEREBY CERTIFY, That I attended deceased from
Aug 8, 19 *22*, to *Aug 9*, 19 *22*
that I last saw him alive on *Aug 9*, 19 *22*
and that death occurred, on the date stated above, at *8 a.m.*
The CAUSE OF DEATH* was as follows:—*Edema Lungs*
(Embo. Premature Birth)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Myocardial Insufficiency*
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *W. J. Seay*, M. D., 19 (Address) *541 N. Madison Ave.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balto Cem.**8/11/22*

20 UNDERTAKER

Philip Herwig

ADDRESS

*2046 Orleans*PHYSICIANS should state
Exact statement of OCCUPA-
tion in very important. See instructions on back of certificates.

State CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 66718

PLACE OF DEATH

REGISTERED NO. C

D 66718

CITY OF BALTIMORE (No. 122 E. Randall St. ST. 24 WARD)

2-FULL NAME Harold E. Shipley

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 122 E. Randall St., St. 4 yrs. 4 mos. 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6-DATE OF BIRTH July 31st, 1922 (Month) (Day) (Year)

7-AGE 4 yrs. 4 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Baby home job

9-BIRTHPLACE (State or country) Baltimore, Md.,

10-NAME OF FATHER Charles Lee Shipley

11-BIRTHPLACE OF FATHER (State or country) Baltimore, Md.

12-MAIDEN NAME OF MOTHER Marie Amelia Johnson

13-BIRTHPLACE OF MOTHER Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mother (Marie Shipley)

(Address) 122 E. Randall St.

AUG 11 1922 ROBERT R. KRAUTER,

Filed 191 Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 11th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 31st, 1922, to August 10th, 1922, that I saw him alive on August 10th, 1922, and that death occurred on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Congenital Stenosis

(Duration) 4 yrs. 4 mos. 7 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) William E. Clifton M. D. August 11, 1922 (Address) 2079 Reisterstown Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

London Pl. bur 8/12, 1922

20-UNDERTAKER ADDRESS

J. F. McLeadbey 130 E. Fort

157457
D 66719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66719

1. PLACE OF DEATH

CITY OF BALTIMORE: (NORMANS HOPKINS HOSPITAL, 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Sallie May

(a) RESIDENCE NO.

413 Mc Carthy St. City

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Married

5a If married, widowed, or divorced

(or) WIFE of

Frank May (husband)

6 DATE OF BIRTH (month, day, and year)

Feb. 1-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

?

?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Maryland

10 NAME OF FATHER

Henry Proctor

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Beatrice Proctor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

JOHNS HOPKINS HOSPITAL, Records

15

AUG 11 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1922

17

I HEREBY CERTIFY, That I attended deceased from July 27, 1922, to Aug 10, 1922.

that I last saw her alive on Aug 10, 1922.

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Chronic nephritis

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY Hypertension - Arterio (Secondary)

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

(Signed)

Myron E. Goldblatt, M. D.

1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Mt Auburn Cem

Aug 11 1922

20 UNDERTAKER

Daniel Estlin

ADDRESS

916

Exact statement of OCCUPATION should state in plain terms, so that it may be properly classified. See instructions on back of certificates.

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66720

CERTIFICATE OF DEATH.

31 D 66720

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 1 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Reeder

(a) RESIDENCE NO. 110 Diamond st.
(Usual place of abode)

ST. _____ WARD _____

Length of residence in city or town where death occurred Unknown mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Dellie Reeder (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895 ?

7 AGE Years 27 ? Months _____ Days _____ If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER Sam. Gray

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Lena Lindsay

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Hospital Records
(Address) M. T. H.

15 AUG 11 1922 ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to Aug. 10, 1922, that I last saw her alive on Aug. 10, 1922, and that death occurred, on the date stated above, at 5 p. m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown
if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Padogliacci M. D.
8-10-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER My Cubun Co

Aug 11, 1922

Daniel Epton

PC an

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66721

CERTIFICATE OF DEATH.

D 66721

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland Penitentiary* ST.: *12* WARD)

2-FULL NAME

Notthern Payne

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *1804 Maryland Ave.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *black* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *August 27, 1896*7 AGE Years *25* Months *11* Days *10* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) *Eastman, Georgia* (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Eastman, Georgia*12 MAIDEN NAME OF MOTHER *Mary Chapman*13 BIRTHPLACE OF MOTHER (city or town) *Georgia* (State or country)

14

Informant (Address)

15

Filed *AUG 11 1922*

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 7, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *April 22, 1922, to August 7, 1922,*that I last saw him alive on *August 7, 1922,*and that death occurred, on the date stated above, at *3:40 p. m.*

The CAUSE OF DEATH* was as follows:

Acute Cordiac Dilatation Endocarditis - Hypostatic congestion of lungs.(duration) yrs. mos. *14* ds.CONTRIBUTORY *Articular Rheumatism* (Secondary)(duration) yrs. *3* mos. *15* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical Examination*(Signed) *William B. Schwartz*, M. D.1922 (Address) *Maryland Penitentiary*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Catharine's Cem. Aug. 12 22

20 UNDERTAKER

David Easton 916 Penn Ave

Physicians should state exact statement of OCCUPATION. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66722

D 66722

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

O. Peter Grau

(a) RESIDENCE. NO.

Hebrew Hospital

ST.:

WARD.

Long Green Md

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

0 yrs.

0 mos.

14 ds.

How long in U. S., if of foreign birth?

68 yrs.

0 mos.

1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Anna P. Grau

6 DATE OF BIRTH (month, day, and year)

March 10-1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

5

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer 186

(b) General nature of industry, business, or establishment in which employed (or employer)

Farming

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Long Green Md

10 NAME OF FATHER

John Grau

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown Germany

12 MAIDEN NAME OF MOTHER

Barbara Seemiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown Germany

14

Informant (Address)

Henry W. Grau (son) Long Green Md

15

1922

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 11th 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 24th, 1922, to Aug 11th, 1922, that I last saw him alive on Aug 11th, 1922,

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH was as follows:

Terminal Broncho Pneumonia & Pulmonary Edema

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Yes

Date of

8/5/22

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) Walter Lindheimer, M. D.

. 19 (Address)

Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Long Green Md

Aug 11/1922

20 UNDERTAKER

ADDRESS

Stewart Mowen Company 108 W. North St. F. Mowen - owner

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66723

D 66723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1317 N. Wolf* ST., *8* WARD)2-FULL NAME *Barbara M. Dreyler*(a) RESIDENCE NO. *1317 N. Wolf*
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

*White*5 Single, Married, Widowed,
or Divorced, (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec 3rd 1896*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*26**years**8**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)*None*

(c) Name of employer

*None*9 BIRTHPLACE (city or town)
(State or country)*Balto
Maryland*

10 NAME OF FATHER

*John M. Dreyler*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balto md*

12 MAIDEN NAME OF MOTHER

*Elizabeth Dreyler*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto md*

14

Informant
(Address)*Catherine Henderson
1317 N. Wolf St*

1922

Robert P. Henderson,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 10 1922*

17

I HEREBY CERTIFY, That I attended deceased from
Aug 5, 1922 to *Aug 10, 1922*
that I last saw her alive on *Aug 10, 1922*
and that death occurred, on the date stated above, at *12.30 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. *6* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?*Place of death*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Usual Clinical*(Signed) *Cell M. Malone*, M. D.1922 (Address) *1540 N. Broadway**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOY

Balto Cemetery

DATE OF BURIAL

Aug 12 1922

20 UNDERTAKER

Robt J. Turner Inc

ADDRESS

1742 N. Broadway

(Vandulie Robinson)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66724

CERTIFICATE OF DEATH.

31 D 66724

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2237 D.N. W. 14 ST. 14 WARD)

2-FULL NAME

Vandulie Robinson

(Residence in Baltimore: No. 2207 D.N. W. 14 ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 14 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Caucasian

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word.)

6-DATE OF BIRTH

Dec. 22, 1910

7-AGE,

17 yrs. 7 mos. 12 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or profession

(b) General nature of industry, business, or establishment in which employed (or employer)

School Teacher

9-BIRTHPLACE, (State or Country),

Balt. City

10-NAME OF FATHER

H. V. Robinson

11-BIRTHPLACE OF FATHER (State or Country),

Balt. City

12-MAIDEN NAME OF MOTHER

Nellie Turner

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

H. V. Robinson
2237 D.N. W. 14 ST. 14 WARD

15-

Filed 11/13/22

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug. 10th, 1922

I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on Aug 9th 1922, and that death occurred, on the date stated above at 11 a.m.

The CAUSE OF DEATH* was as follows:

Sub. 1. Uterine cancer.

CONTRIBUTORY (Secondary)

(Signed) H. V. Robinson M. D.
1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

1922

20-UNDERTAKER

George H. Holland 1631 16th St. N.W.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66725

CERTIFICATE OF DEATH.

179 D 66725

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1438 Belvedere St.) WARD 12

2. FULL NAME

John P. Baker

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1438 Belvedere St. WARD 12

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Mary B. Baker (or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug 25-18477 AGE 74 Years 11 Months 16 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed 522

. 19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1922

17

I HEREBY CERTIFY, That I attended deceased from July 5th 1922, to Aug 9, 1922, that I last saw him alive on Aug 9, 1922, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis & Failure of Heart Compensation
(duration) 7 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

Overexposure & Lead (duration) ? yrs. ? mos. ? ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Examination of(Signed) Geo. H. Holland, M. D., 19 (Address) 426 E. 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MORAL Indefurn Mtg Aug 12, 1922

20 UNDERTAKER

Geo. H. Holland 1631 Union Hill

PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Grendon Ave ST. 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah E Barnes(Residence in Baltimore: No. 117 Grendon Ave St. life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married (Write the word.)6-DATE OF BIRTH, Mar. 23, 1840 (Month) (Day) (Year)7-AGE, 81 yrs. 4 mos. 18 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housework (b) General nature of industry, business, or establishment in which employed (or employer), at Home9-BIRTHPLACE, (State or Country), City10-NAME OF FATHER, John Wickens11-BIRTHPLACE OF FATHER (State or Country), England12-MAIDEN NAME OF MOTHER Unknown13-BIRTHPLACE OF MOTHER (State or Country), England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. F. Berglund(Address) 613 N. Robinson St.

15-

Filed 12 1922 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 14, 1922 (Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Aug 9 1922 to Aug 10 1922, that I saw him live on Aug 9 1922 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Hemiplegia)
(Duration) yrs. mos. ds.CONTRIBUTORY Arterio Sclerosis
(Secondary)(Signed) Clayton M. D.Aug. 14, 1922 (Address) 470 B. Harbor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore DATE OF BURIAL, Aug. 14, 192220-UNDERTAKER Peter & Nicholas ADDRESS 2060 Eastern Ave

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66727

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-083 66727

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. *Johns Hopkins Hospital*)
2-FULL NAME *James L. Rieth*
(Residence in Baltimore: No. *621 S Glover St*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *10* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male*
4-COLOR OR RACE, *White*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*
6-DATE OF BIRTH, *June 26, 1912*
(Month) (Day) (Year)
7-AGE, *10* yrs., *2* mos., *9* ds.
If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *At School*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE. (State or Country), *City*
10-NAME OF FATHER, *Chas H. Rieth*
11-BIRTHPLACE OF FATHER (State or Country), *City*
12-MAIDEN NAME OF MOTHER *Mary E. Arminan*
13-BIRTHPLACE OF MOTHER (State or Country), *City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Mr Chas H. Rieth*
(Address) *621 S Glover St*

15-
Robert P. Harrison,
21922
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 10, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stroke from hemorrhage due to accident
Automobile driven by Charles Brown
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. S. Toller* M. D.
(Coroner.)
8-11-22 (Address) *508 E. North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mount Carmel* DATE OF BURIAL, *Aug 13, 1922*

20-UNDERTAKER, *Peter Nicolaus 2060 Eastern Ave* ADDRESS

D 66728

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66728

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *3735 Eastern Ave* St. *26* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *3735 Eastern Ave* St. *50* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*White*5-Single, Married, Widowed, or Divorced, (Write the word.) *Widowed*

6-DATE OF BIRTH,

*Nov**26**1850*

(Month)

(Day)

(Year)

7-AGE,

*71**8**13*

yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE, (State or Country).

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

Germany

12-MAIDEN NAME OF MOTHER,

Unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Madie Bode*(Address) *3575 Claremont St*

15-

*Robert P. Harrison,**12 1922*

Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Aug 9**1922*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.)find that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Failure at once

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Cirrhosis Liver(Signed) *Thos W. Horton*

(Duration) yrs. mos. ds.

Aug 9 1922(Address) *Curtis Bay**State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. *Accidental*

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Carmel Aug 12 1922

20-UNDERTAKER,

ADDRESS

Peter Nicolaus 2060 Eastern Ave

PHYSICIANS should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

13-465-7 HEALTH DEPARTMENT—CITY OF BALTIMORE

66729

CERTIFICATE OF DEATH.

66729

1. PLACE OF DEATH

CITY OF BALTIMORE: (Name of Hospital, Street, and Ward) *JOHNS HOPKINS HOSPITAL, 5 WARD*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Ruth Jones*

(a) RESIDENCE NO. *1410 Mulliken St.*

(Usual place of abode)

WARD

Length of residence in city or town where death occurred *2 yrs.* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec. 22, 1877*

7 AGE Years *45* Months *7* Days *16* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*

10 NAME OF FATHER *Tom Jones*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Virginia*

12 MAIDEN NAME OF MOTHER *Annie Armstrong*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14 Informant *JOHNS HOPKINS HOSPITAL* (Address)

1922 Robert E. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 10, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *August 8, 1922* to *August 10, 1922* that I last saw her alive on *August 10, 1922* and that death occurred, on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH* was as follows:

Patient died suddenly, 20 hours after operation following an apparently normal post-operative recovery. Autopsy refused.

CONTRIBUTORY (Secondary) *Operation for myomatous uterus & chronic hyperplasia* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Aug 9, 1922*

Was there an autopsy? *Refused*

What test confirmed diagnosis? *0*

(Signed) *Karl H. Mott* M. D.

, 1922 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Asbury Cemetery

Aug 13, 1922

20 UNDERTAKER *Grover T. A. Gibson*

ADDRESS *513 Lawrence St.*

Exact statement of OCCUPATION
See instructions on back of certificate.

D 66730 HEALTH DEPARTMENT—CITY OF BALTIMORE 185 D 66730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 1106 Parish St. 16 Ward)
2-FULL NAME: Geo. H. Clark
(Residence in Baltimore: No. 1106 Parish St. 52 yrs. mos. ds.)

Registered No. C.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M. 4-COLOR OR RACE: Colored 5-Single, Married, Widowed, or Divorced: Married (Write the word.)
6-DATE OF BIRTH: 1. 86 (Month) (Day) (Year)
7-AGE: 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work: Laborer (b) General nature of industry, business, or establishment in which employed (or employer):
9-BIRTHPLACE: (State or Country): Balt Co. Md.
10-NAME OF FATHER: Louis D. Clark
11-BIRTHPLACE OF FATHER: (State or Country): Balt Co. Md.
12-MAIDEN NAME OF MOTHER: Maria Crawford
13-BIRTHPLACE OF MOTHER: (State or Country): Balt Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs. Lora Ruth
(Address): 837 N. Calhoun St.

15- Robert P. Harrison, Registrar.
1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug - 9 - 1922 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.)
that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:
Contused Lungs, Fractured Ribs, Hemorrhage, Shock, Asphyxia, (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) M. D. (Coroner.)
1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

James A. Lewis, 313 E. Pratt St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66731

CERTIFICATE OF DEATH.

179D 66731

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N. Glover ST., 7 WARD)

2-FULL NAME

(a) RESIDENCE No. 616 N. Glover ST., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 23 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

John Pfeifer6 DATE OF BIRTH (month, day, and year) July 16 - 65

7 AGE

Years

Months

Day

If LESS than 1 day, hrs. or min. 57 - 23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER Oscar H. Mace11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14

Informant (Address) John Pfeifer
616 N. Glover

15

Robert F. Harrison,

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 4, 1922, to Aug 9, 1922, that I last saw her alive on Aug 9, 1922, at 7:15 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Intermittent febrile
thral degeneration
(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Gerding(Signed) non, M. D.19 (Address) 800 N. Pitt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Balto Cem.

20 UNDERTAKER

Philip HennigArlemus

DATE OF BURIAL

8/12 1922

ADDRESS

2016Arlemus

PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

157621
D 66732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 66732

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Annie Carson

(a) RESIDENCE NO. 1739 E. Baltimore St. WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

18 years

How long in U. S., if of foreign birth?

Yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, (or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mrs. Bessie Bradford (sister)

6 DATE OF BIRTH (month, day, and year) Nov. 16 18 ?

7 AGE Years 49 Months ? Days ? If LESS than 1 day, ? hrs. or ? min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa. (State or country)

10 NAME OF FATHER James Carson

11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country)

12 MAIDEN NAME OF MOTHER Charlotte Johnson

13 BIRTHPLACE OF MOTHER (city or town) Pa. (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed Robert P. Harrison 19 1922

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1922, to Aug 10, 1922, that I last saw her alive on Aug 10, 1922,

and that death occurred, on the date stated above, at 1045 A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 7 ds.

CONTRIBUTORY Diabetes Mellitus (Secondary)

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of operation

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy (Signed) Myron Z. Galeski, M. D.

1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Arbury

DATE OF BURIAL

Aug 11, 22
ADDRESS 1504

20 UNDERTAKER

John W. Henderson Emment

PHYSICIANS SHOULD SIGN IN FULL, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66733 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66733

CERTIFICATE OF DEATH

1-PLACE OF DEATH *Mercy Hospital* 4
City of BALTIMORE: (No. *Not known*) St. *Not known* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Not known*
(Residence in Baltimore: No. *Not known* St.; yrs. *Not known* mos. *Not known* ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, <i>male</i>	4-COLOR OR RACE, <i>white</i>	5-Single, Married, Widowed, or Divorced, (Write the word.)	16-DATE OF DEATH, <i>July 4</i> 192 <i>2</i> (Month) (Day) (Year)	
6-DATE OF BIRTH, (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry,) find that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows: <i>Multiple fracture over</i>	
7-AGE, <i>50</i> yrs. <i>Not known</i> mos. <i>Not known</i> ds. If LESS than 1 day, <i>Not known</i> hrs. or <i>Not known</i> min.			(Duration) <i>Not known</i> yrs. <i>Not known</i> mos. <i>Not known</i> ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).			CONTRIBUTORY (Secondary) (Duration) <i>Not known</i> yrs. <i>Not known</i> mos. <i>Not known</i> ds. (Signed) <i>Not known</i> M. D. (Coroner.) 192 (Address) <i>Not known</i>	
9-BIRTHPLACE, (State or Country).			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS.	10-NAME OF FATHER,		18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death <i>Not known</i> yrs. <i>Not known</i> mos. <i>Not known</i> ds. In the State <i>Not known</i> yrs. <i>Not known</i> mos. <i>Not known</i> ds. Where was disease contracted, if not at place of death?	
	11-BIRTHPLACE OF FATHER, (State or Country).		Former or usual residence, <i>Not known</i>	
	12-MAIDEN NAME OF MOTHER,		19-PLACE OF BURIAL OR REMOVAL, <i>PUBLIC CEMETERY.</i> DATE OF BURIAL, <i>AUG. 11 1922</i>	
	13-BIRTHPLACE OF MOTHER, (State or Country).		20-UNDERTAKER, <i>Commissioner of Health.</i> ADDRESS <i>Not known</i>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Not known</i> (Address) <i>Not known</i>				
15- <i>Robert P. Harrison,</i> <i>121922</i> 1922 <i>Burial Permit Clerk.</i> Registrar.				

History from Mercy Hospital was struck by auto while crossing street.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia," (merely symptomatic), "At-rophy," "Collapse," "Coma," "Convulsions," "De-bility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite dis-ease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERP-ERAL peritonitis," etc. State cause for which sur-gical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Ex-amples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homi-cide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional in-formation which may give any of the following diseases, without explanation as the sole cause of death:

<i>Abortion,</i>	<i>Hemorrhage,</i>	<i>Meningitis,</i>	<i>Phlebitis,</i>
<i>Cellulitis,</i>	<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Pjemia,</i>
<i>Childbirth,</i>	<i>Gastritis,</i>	<i>Necrosis,</i>	<i>Septicemia,</i>
<i>Convulsions,</i>	<i>Erysipelas,</i>	<i>Peritonitis,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

D 66734

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66734

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *940 W Franklin St.* ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ester Farrell.

(a) RESIDENCE. NO.

940 W Franklin St. ST.: _____ WARD: _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *26* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced (or) WIFE of *Jessie J. Farrell*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *26* Months *1* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Isiah D. Luck*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md.*12 MAIDEN NAME OF MOTHER *Alice Jones*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md.*

14

Informant (Address) *940 W. Franklin St.*

15

Filed

2 1922

19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 11* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *June 15*, 19 *22*, to *Aug 11*, 19 *22*, that I last saw him alive on *Aug 11*, 19 *22*, and that death occurred, on the date stated above, at *11 a. m.*

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs(duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *at home* if not at place of death?Did an operation precede death? *no* Date of _____Was there an autopsy? *no*What test confirmed diagnosis? *physical*(Signed) *Robert P. Harrison*, M. D.19 (Address) *114 Park Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Robert P. Harrison

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66735

CERTIFICATE OF DEATH.

113 D 66735

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *615 Brune* St.;

17

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Alicia Davis*(Residence in Baltimore: No. *615 Brune St.* St.;

yrs.,

6

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH

February

(Month)

(Day)

19*22*

(Year)

7-AGE,

6 yrs. *10* mos. *10* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Leah Davis(Address) *615 Brune St*

15-

Robert F. Harrison,

Filed....., 191.....

2 1922

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*August**11*

(Month)

(Day)

191*22*

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 8 191*22*, to *Aug 10* 191*22*that I saw her alive on *Aug 10* 191*22*and that death occurred, on the date stated above, at *11:15* a.m.

The CAUSE OF DEATH* was as follows:

Decomposition Intestines

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

Aug 11, 191*22* (Address) *5411 N. Myrtle*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Lenox Cemetery**Aug 12*, 191*22*

20-UNDERTAKER

ADDRESS

Mrs. Geo. H. Wolfe 406 N. Conway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66736

CERTIFICATE OF DEATH.

31 D 66736

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1232 Mc Elderry ST. 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Reginald Johnson

(Residence, in Baltimore: No.

1232 Mc Elderry

St.: 16 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M 4-COLOR OR RACE, C 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, Aug 27, 1890 (Month) (Day) (Year)

7-AGE, 21 yrs., 11 mos., 14 ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Porter 070 (b) General nature of industry, business, or establishment in which employed (or employer), Porter for jewelry store

9-BIRTHPLACE, (State or Country), Va.

10-NAME OF FATHER, Moses Johnson
11-BIRTHPLACE OF FATHER (State or Country), Va
12-MAIDEN NAME OF MOTHER, Maggie Finney
13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rosie Johnson (wife)

(Address) 1232 Mc Elderry St

15-

Robert P. Harrison,
Filed 191

1922 Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 / 10, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1922, to Aug 10 1922, that I saw him alive on Aug 19 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia T.B.C.
(Duration) since June 1922 to Aug 10 1922

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) R. P. Harrison, M. D.
8/11, 1922 (Address) 1429 E. Washington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery DATE OF BURIAL, Aug 13, 1922

20-UNDERTAKER, Robert Williams ADDRESS, 106 Ashland St

Important. See instructions on back of certificate. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PHYSICIANS SHOULD
is very important. See instructions on back of certificate.

D 66737 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1111 Curtis Ave. Curtis Bay St. 25 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Wasil Kurelych.

(Residence in Baltimore: No. 1111 Curtis Ave. Curtis Bay St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Single, Widowed, or Divorced. (Write the word.)
Male. White.

6-DATE OF BIRTH, Do not know. 1.
(Month) (Day) (Year)

7-AGE, 40 If LESS than 1 day, yrs. mos. ds. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Ramawski.

(Address) 1111 Curtis Ave. Curtis Bay

15- Robert F. Harrison,

Filed, 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 5th. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [Signature] M. D. (Coroner)

Aug. 10, 1922 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

PUBLIC CEMETERY.

20-UNDERTAKER, ADDRESS

Aug 11 1922

D 66738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66738

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 N. Washington ST., 6 WARD)

2-FULL NAME

William H. Lambdin

(a) RESIDENCE NO.

124 N. Washington ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7/227 AGE Years Months Days If LESS than 1 day, hrs. or min. 4 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.10 NAME OF FATHER W. C. Lambdin11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.12 MAIDEN NAME OF MOTHER Calarsia Ball13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14

Informant (Address)

W. C. Lambdin
124 N. Washington

15

Date

Robert E. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 19 2217 I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to Aug. 10, 1922, that I last saw him alive on Aug. 10, 1922, and that death occurred, on the date stated above, at 120 P. m.

The CAUSE OF DEATH* was as follows:

Transition(duration) yrs. 1 mos. 14 ds.CONTRIBUTORY (Secondary) Gastro Enteritis(duration) yrs. 2 mos. — ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? No Date of ✓Was there an autopsy? NoWhat test confirmed diagnosis? usual symptoms(Signed) Wm. J. Pillsbury, M. D.8/11, 1922 (Address) 415 Cedarscroft Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral8/12 1922

20 UNDERTAKER

ADDRESS

John A. Moran 3005 E. Balt.

Burial Permit Clerk

PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66739

CERTIFICATE OF DEATH.

66739

1-PLACE OF DEATH

City of BALTIMORE: (No. *614 Water St.* St. *4* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *614 Water St.* St.; yrs. *55* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE. *white* 5-Single, Married, *widowed*, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH. *March 5* 1867 (Month) (Day) (Year)

7-AGE. *55* yrs. *5* mos. *5* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Retired* (b) General nature of industry, business, or establishment in which employed (or employer). *Saloon keeper*

9-BIRTHPLACE. (State or Country). *Baltimore*

10-NAME OF FATHER. *Frank J. Conway*

11-BIRTHPLACE OF FATHER. (State or Country). *Baltimore*

12-MAIDEN NAME OF MOTHER. *Maggie Kennedy*

13-BIRTHPLACE OF MOTHER. (State or Country). *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). *Mrs. Mary P. Heston*

(Address). *614 Water St.*

15- Robert P. Harrison, Registrar.

1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Aug 10* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction (Duration) yrs. *2* mos. *1* ds.

CONTRIBUTORS (Secondary) *Arteriosclerosis*

(Signed) *John J. Conway* M. D. (Coroner.)

1922 (Address) *901 Hollins St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. *55* mos. *5* ds. In the State. yrs. *55* mos. *5* ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St. John's Cemetery Aug 14 1922

20-INTERMENTED BY *John J. Conway* ADDRESS *901 Hollins St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66741

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 Harlem Ave. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 903 Harlem Ave. St.; 71 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, — DIVORCED, — (Write the word.)6-DATE OF BIRTH, Jan 20, 1882 (Month) (Day) (Year)7-AGE, 72 yrs., 6 mos., — ds. If LESS than 1 day, — hrs. or — min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, Retired (b) General nature of industry, business, or establishment in which employed (or employer), Stone Cutter9-BIRTHPLACE, (State or Country), Ireland10-NAME OF FATHER, Geo Tracy11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER, Sarah Risher13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. S. R. Tracy(Address) 903 Harlem Ave.

15-

Filed Robert P. Harrison, 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 11, 1922 (Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from June 7, 1922, to Aug 11, 1922, that I saw him alive on Aug 11, 1922, and that death occurred, on the date stated above, at 11:4 a.m.

The CAUSE OF DEATH* was as follows:

Pericarditis (Duration) 6 yrs., 6 mos., — ds.CONTRIBUTORY (Secondary) Coronary Artery Disease(Duration) 7 yrs., — mos., — ds. (Address) 101 N. Calver

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, Aug 14, 192220-UNDERTAKER, John O. Mitchell ADDRESS 124 W. Fayette

1922

Important. See instructions on back of certificate.

D 66742

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66742

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1821 Vile St.* ST. *20* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Robert Meade(a) RESIDENCE, NO. *1821 Vile* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Continuum 1864*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamster

(b) General nature of industry, business, or establishment in which employed (or employer)

023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

Meade

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Gen. W. H. H. H.

15

Filed

Robert E. Harrison,

Registrar

12 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 9* 19 *22*17 HEREBY CERTIFY, That I attended deceased from *June 15*, 19 *22*, to *Aug 9*, 19 *22*That I last saw him alive on *Aug 8*, 19 *22*and that death occurred, on the date stated above, at *8* a.m.

The CAUSE OF DEATH* was as follows:

Chl Nephritis(duration) yrs. *3* mos. ds.

CONTRIBUTORY (Secondary)

Roma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Walter H. White Jr.* M. D.8/11/22 Address) *2800 St Paul St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mr. Auburn Cem**Aug 12 1922*

20 UNDERTAKER

ADDRESS

John Parkman 220 Hamburg St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66743

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *67-E-Heath*)ST. *23* WARD

2. FULL NAME

(a) RESIDENCE NO. *67-E-Heath*

(Usual place of abode)

ST. *23* WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *4* yrs. *1* mos. *1* ds.How long in U. S., if of foreign birth? *1* yrs. *1* mos. *1* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*5 Single Married Widowed, or Divorced (or WIFE of *George W. Seitz*)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 26 1869*

7 AGE

Years *52*Months *8*

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md.*10 NAME OF FATHER *Francis Dillingham*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Mars*12 MAIDEN NAME OF MOTHER *Harlan M. Cooper*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Mars*

14

Informant (Address) *Geo. W. Seitz 67 E. Heath*

15

2 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8-12-1922*

17

I HEREBY CERTIFY, That I attended deceased from *July 10, 1922, to Aug 12, 1922,* that I last saw him alive on *Aug 11, 1922,* and that death occurred, on the date stated above, at *30* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia
*Arterio Sclerosis*CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *Senile dementia*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Wm. H. H. H.* M. D., 19 (Address) *630 E. Heath St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Bluff Annapolis

20 UNDERTAKER

Wm. H. H. H.

DATE OF BURIAL

8/14 1922

ADDRESS

502 E. Heath

This is very important. See instructions on back of certificates. Exact statement of OCCURRENCE.

157651,
D 66744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 66744

1-PLACE OF DEATH

CITY OF BALTIMORE: (NOVINS HOPKINS HOSPITAL, 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Bena.

(a) RESIDENCE NO. 1327 Port St. City ST.,

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 19 years

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Margaret Bena (wife)

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1886

7 AGE 36. Years 6. Months 5. Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Glass (Blower)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York

10 NAME OF FATHER

August Bena

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

New York

12 MAIDEN NAME OF MOTHER

Vie Goschdomde

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

France

14

Informant: JOHNS HOPKINS HOSPITAL, Records

15

Robert F. Harrison,

1922

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 8, 1922, to Aug 11, 1922.

that I last saw him alive on Aug 11, 1922.

and that death occurred, on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

E. C. Boyer, M. D.

1824 Address

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oaklawn

DATE OF BURIAL

Aug 14, 1922

20 UNDERTAKER

Jickler & Jickler

ADDRESS

1734 Eager

D 66745

D 66745

Spec.—6-9-19—H. P. Co.—1000 Bks.

66745 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Hillman ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matthew Minor

(a) RESIDENCE. No. 914 Hillman ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of Helen Minor

6 DATE OF BIRTH (month, day, and year)

7 AGE 34 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina (State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) N C (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) N C (State or country)

14 Informant Helen Minor (Address) 914 Hillman St

15 Filed AUG 13 1922 ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 4 1922 to Aug 8 1922

that I last saw him alive on Aug 8 1922

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lobes Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. H. Hornstein M. D.

810, 1922 (Address) 733 Argus St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Norfolk Va.

DATE OF BURIAL

Aug 12 1922

20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS 1726-

Arlington

PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

66746

HEALTH DEPARTMENT—CITY OF BALTIMORE

66746

D 66746

CERTIFICATE OF DEATH.

179

D 66746

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Clara Joyce

(a) RESIDENCE NO.

904 Park Ave

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Not-married*

6 DATE OF BIRTH (month, day, and year) *1863*

7 AGE Years *59* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Charles Joyce

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Melinda

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

William Joyce 904 Park Ave

15

Filed *Aug 13 1922*

ROBERT R. KRAUTER Registrar

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 11 1922*

17 I HEREBY CERTIFY, That I attended deceased from *July 31 1922* to *Aug 11 1922*, that I last saw him alive on *Aug 11 1922*, and that death occurred, on the date stated above, at *1:45* m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Infarction
Chronic Interstitial Nephritis

(duration) *10* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Specimen + Specimen*

(Signed) *J. S. Rogers* M. D.

(Address) *Maryland*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laural Cemetery

DATE OF BURIAL

Aug 14 1922

20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS

Ashland

is very important. See instructions on back of certificate.

D 66747 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *4* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *636 W Lombard* St.; yrs. *20* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Single* (Write the word.)

6-DATE OF BIRTH, *Don't know* (Month) (Day) (Year)

7-AGE, *38* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Tailor* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Lithuania*

10-NAME OF FATHER, *Martin Spudis*

11-BIRTHPLACE OF FATHER, (State or Country), *Lithuania*

12-MAIDEN NAME OF MOTHER, *Anna Tauskas*

13-BIRTHPLACE OF MOTHER, (State or Country), *Lithuania*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Spudis*

(Address) *636 W Lombard St*

15-

AUG 13 1922 192 *ROBERT B. KRAUTER* Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 12* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* ~~autopsy~~ *inquiry* thereon and from the evidence obtained by said *inquest* ~~autopsy~~ *inquiry* and that said deceased came to *this* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Bullet wound in Brain*

(Duration) *a few hours* ds.

CONTRIBUTORY *Smoking* (Secondary) (Duration) *a few hrs* ds.

(Signed) *W. J. Gorman* M. D. (Coroner.)

8-12-1922 (Address) *117 W. Sackett St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Holy Redeemer Aug 14 1922

20-UNDERTAKER, ADDRESS

John G. Williams 425 S. Paca St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66748

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 45 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

Nov 22^d, 1887
(Month) (Day) (Year)

7-AGE,

85 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

John E. Berley

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Don't Know

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Theresa E. Berley

(Address)

1827 W. Pratt St

15-

Filed..... 191.....

ROBERT M. K. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 11, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 8 1922, to Aug 11 1922,

that I saw her alive on Aug 11 1922,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration)..... yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(Duration)..... yrs. mos. ds.

(Signed) Cha. A. Schaefer M. D.

Aug 12, 1922 (Address) 53 E. Fulton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Cathedral

DATE OF BURIAL,

Aug 12, 1922

20-UNDERTAKER

Geo. Leimbach & Son

ADDRESS

647 W. Pratt St

AUG 13 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66749

D 66749

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1003 Ridgely St*)ST.: *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Friedrich Miller

(a) RESIDENCE. NO.

*1003 Ridgely*ST.: *21* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos.ds. How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Bertha Miller*

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.*74*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoe maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Germany*

10 NAME OF FATHER

William Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)*Mrs Bertha Miller
1003 Ridgely St*

15

Filed

Aug 13 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 1 1922, to *Aug 11 1922*,that I last saw him alive on *Aug 10 1922*and that death occurred, on the date stated above, at *6 P.* m.

The CAUSE OF DEATH* was as follows:

Suburitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *C*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Edw. G. Smith*, M. D.8/12/1922 (Address) *517 Lehigh*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cemetery**Aug 14 1922*

20 UNDERTAKER

ADDRESS

*Geo. Leimbach & Son**687 W. Pratt*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66750

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Church Home and Infirmary*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *126 N. Broadway* ST., *7* WARD)2. FULL NAME *William S. Shapiro*(a) RESIDENCE NO. *912 N. Bedford St.* ST., *7* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*6 DATE OF BIRTH (month, day, and year) *Aug 27 1908*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*13**11**14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Alcohol

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John Shapiro

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary March

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

John Shapiro 912 N. Bedford St.

15

Filed *1-3-1922*

ROBERT R. KRAUTER

Burial Permit *Check*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 10 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*July 29 1922, to Aug 10 1922.*that I last saw him alive on *Aug 10 1922*and that death occurred, on the date stated above, at *6:00 P. m.*

The CAUSE OF DEATH* was as follows:

*Intestinal Obstruction
General Peritonitis*(duration) yrs. mos. *3* ds.

CONTRIBUTORY (Secondary)

Acute Appendicitis(duration) yrs. mos. *12* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *July 29 1922*Was there an autopsy? *no*What test confirmed diagnosis? *Operation*(Signed) *Richard J. Coffey* M. D., 19 (Address) *Church Home and Inf.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer

DATE OF BURIAL

Aug 14 1922

20 UNDERTAKER

Paul Swackham

ADDRESS

116 N. 1st St.

PHYSICIANS should state EXACTLY. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66751

113 D 66751

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 840 E. Pratt ST., 3 WARD)

2. FULL NAME

(a) RESIDENCE NO. 840 E. Pratt

(Usual place of abode)

ST., _____ WARD _____

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Nov-3-1921

7 AGE

9 Years9 Months8 Days

If LESS than 1 day, _____ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(h) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Augusto De Persio

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Margherita De Angelis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Augusto De Persio
840 E. Pratt

15

AUG 13 1922ROBERT R. KRAUTER,
Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 8, 1922, to Aug 12, 1922

that I last saw him alive on _____, 19____,

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

acute Gastroenteritis(duration) _____ yrs. _____ mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) [Signature], M. D.19 (Address) #222 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

St Vincent Cem

DATE OF BURIAL

Aug 13 1922

20 UNDERTAKER

Geo. J. Ruth

ADDRESS

1735 Bayview

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (JOHNS HOPKINS HOSPITAL, 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Antoinette Livorsi.

(a) RESIDENCE NO.

316 East St., City

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

? yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 9, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Maryland.

10 NAME OF FATHER

Peter Livorsi.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Italy.

12 MAIDEN NAME OF MOTHER

Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Italy.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL, Records.

15

Filed AUG 13 1922

ROBERT H. KROUTER

Burial Permit Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from August 10, 1922, to August 11, 1922, that I last saw her alive on August 11, 1922, and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

T. B. Gay

M. D.

, 1922 (Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Vincent Cem

DATE OF BURIAL

8/13/22

20 UNDERTAKER

Geo. J. Ruth

ADDRESS

1725 Highland

D 66753

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

113 D 66753

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 N. Belvidere ST. WARD)2-FULL NAME Lillian Chrisdi

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 633 N. Belvidere ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 1 - 19217 AGE 1 Years 12 Months 12 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.10 NAME OF FATHER Vincenzo Chrisdi11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy12 MAIDEN NAME OF MOTHER Maria Crimi13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy14 Informant Vincenzo Chrisdi (Address) 633 N. Belvidere15 Filed AUG 13 1922 ROBERT R. KRAVITZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1922, to Aug. 12, 1922, that I last saw her alive on Aug. 12, 1922, and that death occurred, on the date stated above, at 6 P. m.The CAUSE OF DEATH* was as follows:
Gastro-Enteritis.(duration) yrs. mos. ds. 7CONTRIBUTORY Toxemia (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? NoWhat test confirmed diagnosis? (Signed) Wm J. Schmitz M. D.Aug 12 1922 (Address) 701 N. Meridale Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer20 UNDERTAKER Geo. J. Puth 1735 Harford

PHYSICIANS should state EXACTLY. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 66754

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1643 Cliftview Ave. ST., 8 WARD)

2-FULL NAME

Mildred Irene Kronau(a) RESIDENCE No. 1643 Cliftview Ave. ST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? Frederick Md. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of Earl Kronau (or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug. 10th, 18957 AGE Years 27 Months 2 Days days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md. (State or country)10 NAME OF FATHER Ernest Moberly11 BIRTHPLACE OF FATHER (city or town) Frederick Md. (State or country)12 MAIDEN NAME OF MOTHER Alice G. Anderson13 BIRTHPLACE OF MOTHER (city or town) Frederick Md. (State or country)14 Informant Ernest L. Moberly (Address) 1643 Cliftview Ave.15 Filed Aug 13 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 192217 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Aug 12, 1922.that I last saw her alive on Aug 11, 1922, and that death occurred, on the date stated above, at 1:30 P. m.The CAUSE OF DEATH* was as follows:
Tuberculosis of LungsAlcohol 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel S. Schuler M. D.(Address) 1412 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Parkwood Cem
Geo J. Ruth 1735 Hayford

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66755

HEALTH DEPARTMENT—CITY OF BALTIMORE

66755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

115 Aisquith St

REGISTERED NO.

CITY OF BALTIMORE: (No.

Nehrem aged same 5

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Beckie Fine

(a) RESIDENCE NO.

115 Aisquith St

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos.

ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Benj Fine

6 DATE OF BIRTH (month, day, and year)

1855

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or, min.

67

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Russia

10 NAME OF FATHER

Solomon Lerner

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Lerner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant
(Address)Jack Lewis
1439 E. Balt St

15

AUG 13 1922

ROBERT H. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 10 1918 to Aug. 12 1922.

that I last saw her alive on August 12 1922.

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 4 yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)

Pulmonary Emphysema

(duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical examination

(Signed) Morris Abramowitz, M. D.

19 (Address) 1707 E. Balt. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR RE-

MOVAL
Nehrem Rosedale

DATE OF BURIAL

8/13 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Balt St

DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

PHYSICIANS SHOULD STATE EXACTLY. PHYSICIANS SHOULD STATE EXACTLY. PHYSICIANS SHOULD STATE EXACTLY.

D 66756 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Monument Street ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Kratshner.

(a) RESIDENCE. NO. 131 N. Gay St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) married.

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mrs. Matilda Kratshner.

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE 49 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Samuel Kratshner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant (Address) 400 N. Gay St.

15

AUG 13 1922

ROBERT R. KRAHNER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 11, 1922 to August 11, 1922.

that I last saw him alive on August 11, 1922.

and that death occurred, on the date stated above, at 11:25 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Pleurisy.

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Chronic Nephritis, Arteriosclerosis, Hypertension (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann test, etc.

(Signed)

947 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Hospital

8/13 1922

20 UNDERTAKER

ADDRESS

Julius Louis 1439 E. Mt. Vernon St.

PHYSICIANS should state EXACTLY. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Hks.
D 66757
HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.
1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 317-N Mount ST., 19 WARD)
2-FULL NAME Samuel Paul Jackson
(a) RESIDENCE No. 317-N Mount ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
PERSONAL AND STATISTICAL PARTICULARS
3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)
6 DATE OF BIRTH (month, day, and year)
7 AGE Years Months Days If LESS than 1 day, hrs or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country)
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country)
14 Informant (Address)
15 Filed 19
ROBERT R. KRAUTER
Burial Permit
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
16 DATE OF DEATH (month, day, and year)
17 I HEREBY CERTIFY, That I attended deceased from to , 19 .
that I last saw him alive on , 19 .
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) M. D.
, 19 (Address)
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)
19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL
20 UNDERTAKER ADDRESS

Spec. 1-10-21 M&T 1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66757

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317-N Mount ST., 19 WARD)

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTER

Burial Permit

Register

20 UNDERTAKER

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from to , 19 .

that I last saw him alive on , 19 .

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

66758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2001 Hammond St.* ST.: *9* WARD)

2-FULL NAME

*Charles E. Wade*REGISTERED NO. *66758*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *2001 Hammond St.* ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Ruth M. Wade*

6 DATE OF BIRTH (month, day, and year)

Apr. 1843

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*78**4**—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Charles Co. Md.*

10 NAME OF FATHER

Richard Wade

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Charlotte S. Wade

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant
(Address)*Miss Wade
2001 Hammond St.*

15

Filed

19

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 10* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

July 11, 19 *22*, to *Aug 10*, 19 *22*,that I last saw him alive on *Aug 10*, 19 *22*,and that death occurred, on the date stated above, at *—* m.

The CAUSE OF DEATH* was as follows:

Paralysis - 000

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Henry B. ...*, M. D., 19 (Address) *1100 ...*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral**Aug 14* 19 *22*

20 UNDERTAKER

ADDRESS

*C. W. Wedgfield**501 E. ...*

Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 13 1922

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Phy. did not think
was apoplectic. No
other abnormal condition*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital*)ST.: *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Anna C. Wall*(a) RESIDENCE. No. *4001 Howard Ave*
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced
HUSBAND of *Harry Wall*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
39

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto*
(State or country)10 NAME OF FATHER *Thomas Bell*11 BIRTHPLACE OF FATHER (city or town) *Balto*
(State or country)12 MAIDEN NAME OF MOTHER *Emma Keldyff*13 BIRTHPLACE OF MOTHER (city or town) *Balto*
(State or country)14 Informant *Emma Keldyff*
(Address) *4001 Howard Ave*15 Filed *19* *AUG 13 1922* *ROBERT R. KRAUTER, Registrar*
Seal of Health Dept.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 11* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 3, 1922*, 19*22*, to *Aug 11*, 19*22*, that I last saw him alive on *Aug 11*, 19*22*, and that death occurred, on the date stated above, at *2:15 P.* m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia(duration) yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted?
if not at place of death?Did an operation precede death? *No* Date of *Aug 3, 1922*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical Findings*(Signed) *Geo. H. W. W. W.*, M. D.. 19 (Address) *St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral *Aug 14 1922*

20 UNDERTAKER ADDRESS

E. V. W. W. W. *518 22nd*

ADDRESS

90 ✓ 66761

CERTIFICATE OF DEATH.

REGISTERED No.

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 27 W. Preston
(Usual place of abode)

ST., WARD.

WARD.

Length of residence in city or town where death occurred 2 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ d. (If nonresident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1922

I HEREBY CERTIFY, That I attended deceased from
Jan. 29, 1920, to Aug 12, 1922.
that I last saw her alive on Aug 12, 1922

and that death occurred, on the date stated above, at 6:40 p.m.
The CAUSE OF DEATH* was as follows:

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) post

(c) Name of employer

The CAUSE OF DEATH was as follows:

Chronic Myocarditis.

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death? Rocky Mount, N.C.

Did an operation precede death? *no* Date of _____

Was there an autopsy? no.

What test confirmed diagnosis? *Physical Examination*
(Signed) *A. C. G. Hapleton*, M. D.
, 19 (Address) *1315 W. Royal Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
---	----------------

Rocky Mount N. C. Aug 13th

20 UNDERTAKER	ADDRESS
<i>James H. [unclear]</i>	<i>1101 [unclear]</i>

Wm. H. Wainson 118 Wain Royal Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66762

CERTIFICATE OF DEATH.

49 D 66762

1-PLACE OF DEATH

Municipal Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ST., WARD)

2-FULL NAME

Joseph Gutowski

(a) RESIDENCE No.

1604 Lancaster

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

M

W

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Paul J. Gutowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Rozalia Ponatowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Hosp. Records

15

Filed

19

ROBERT R. KESTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 10, 1922, to Aug. 11, 1922

that I last saw him alive on Aug. 11, 1922

and that death occurred, on the date stated above, at 9:10 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx

(duration) 1-2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Laryngeal Obstruction

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Yes

Did an operation precede death?

Yes

Date of 8-11-22

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) Chas. McNeill, M. D. 12-10-22 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus Ch.

August 14, 1922

20 UNDERTAKER

ADDRESS

M. J. Sadowski

405 S. Gun St.

PHYSICIANS should state EXACTLY, in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. — 1-10-21 — M&T — 1500 Rks.

Every item of information should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66763

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

Robert Garrett Childs Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frank Szocik

(a) RESIDENCE NO.

612 S. Port St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

1

mos.

1

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 2, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Szocik (Szoczka)

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Mary Furman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant

(Address)

M. J. Sadowski. for John Szocik. 705 S. Ann St. - 612 S. Port St.

15

Filed

19

Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 10 - 1922, to Aug. 12 - 1922, that I last saw him alive on Aug. 12 - 1922, and that death occurred, on the date stated above, at 12.30 A. M.

The CAUSE OF DEATH* was as follows:

Decomposition Intestinalis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

Acute Ile - Colitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

Philibert Artigiani, M. D.

, 19

(Address)

2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Rosary Cem.

DATE OF BURIAL

Aug 13th 1922

20 UNDERTAKER

M. J. Sadowski

ADDRESS

705 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

15-7527
B 66764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST. 9 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Hopkins Clark

(a) RESIDENCE NO. Ellicott City, Md.
(Usual place of abode)

WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred none yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a. If married, widowed, or divorced

HUSBAND OF
(or) WIFE OF

6 DATE OF BIRTH (month, day, and year) Oct 12, 1917

7 AGE 4 Years 10 Months 1 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER James Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ellicott City, Md.

12 MAIDEN NAME OF MOTHER Miss Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ellicott City, Md.

14 Informant JOHNS HOPKINS HOSPITAL
(Address) Records

15 AUG 13 1922
Filed 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1922, to Aug 13, 1922,

that I last saw him live on Aug 13, 1922,

and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - requiring operation and medulla - brain stem

(duration) yrs. 3-4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 12 1922

Was there an autopsy? Partial

What test confirmed diagnosis? Operation

(Signed) F. L. Reichert, M. D.

, 1922 Address Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Johns Ellicott City, Md Aug 19 22

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

D 66765

HEALTH DEPARTMENT—CITY OF BALTIMORE

66765

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Nursery and Childs Hosp. ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chester Arnold

(a) RESIDENCE. No. 26 N. Bond Street.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 6, 21

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 0 11 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) *****

(c) Name of employer *****

9 BIRTHPLACE (city or town) Baltimore Maryland.

10 NAME OF FATHER Mitchell Arnold

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.

12 MAIDEN NAME OF MOTHER Rosaline Blumenthal

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Maryland

14 Informant Mitchell Arnold (Address) 1621 Bond St.

15 Filed AUG 13 1922 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12, '22 19

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to Aug. 12, '22. 19 that I last saw him alive on Aug. 12, '22, 19 and that death occurred, on the date stated above, at 10.57 p.m. The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (Unresolved)

(duration) 0 yrs. 1 mos. 10 ds.

CONTRIBUTORY Acute myocarditis (Secondary)

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) MacFarrington M. D.

(Address) 1007 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hebrew Herring Run Aug 13 1922

20 UNDERTAKER ADDRESS 1127

Mr. Jensen E. Bullock

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66766

CERTIFICATE OF DEATH.

X 37 D 66766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital ST. 7

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Clarence C. Pusey

(a) RESIDENCE. No.

Havre de Grace, Md.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

6

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Mattie Pusey

6 DATE OF BIRTH (month, day, and year)

1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

secretarial work

(b) General nature of industry, business, or establishment in which employed (or employer)

off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Geo. Pusey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Record.

15

AUG 13 1922

ROBERT J. WRAUTER

Baltimore Health Dept. Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 7, 1922, to Aug. 13, 1922,

that I last saw him alive on Aug. 13, 1922,

and that death occurred, on the date stated above, at 12.40 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis following Pleurisy with Effusion

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Buena Vista, Md.

Did an operation precede death? no Date of

no

Was there an autopsy?

What test confirmed diagnosis?

spinal fluid(?)

(Signed)

Isidore J. Jure

M. D.

, 19 (Address)

Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Havre de Grace Md 8-13 1922

20 UNDERTAKER

ADDRESS

E. B. Harle 115 E. West St.

is very important. See instructions on back of certificate.

D 66767

HEALTH DEPARTMENT—CITY OF BALTIMORE

66767

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1573 Berard St., 14 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1573 Berard St., yrs., mos., ds.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black

5-Single,

Married, Widowed or Divorced (Write the word.)

6-DATE OF BIRTH,

April 14, 1922 (Month) (Day) (Year)

7-AGE,

7 yrs., 7 mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country)

10-NAME OF FATHER,

George B. Berard

11-BIRTHPLACE OF FATHER,

Me

12-MAIDEN NAME OF MOTHER,

Mary Goldring

13-BIRTHPLACE OF MOTHER,

Me

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

AUG 13 1922

ROBERT H. KRAUTH

Bureau Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 11, 1922 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis (over)

CONTRIBUTORY (Secondary)

(Signed)

(Coroner)

1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residences.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

MT Adm Dr

Aug 13, 1922

20-UNDERTAKER,

Daniel Laski

ADDRESS

916

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D 66768

D 66768
1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1300 S. Charles. ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James Frances Morgan

(a) RESIDENCE. NO.

1300 S. Charles

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Theresa E. Morgan

6 DATE OF BIRTH (month, day, and year)

June 16, 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

1

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

Builder

(c) Name of employer

Himself

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't know

14

Informant (Address)

Theresa E. Morgan 1300 S. Charles St

15

AUG 14 1922

ROBERT K. KRAUTER,

Burial Permit 677

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1922

17

I HEREBY CERTIFY, That I attended deceased from August 2, 1922, to August 10, 1922, that I last saw him alive on August 10, 1922, and that death occurred, on the date stated above, at 9:10 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) 4 mos. ds.

CONTRIBUTORY (Secondary)

Hypertensive Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. A. B. A. Meyer, M. D.

M. 11, 1922 Address 2838 Guilford Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Olivet Cemetery

DATE OF BURIAL

Aug 14 1922

20 UNDERTAKER

Mr. Mrs. J. R. Teufelr Son

ADDRESS

301 W. Fayette St.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

For information of physicians, should state exact statement of occupation in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 66769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001
D 66769

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1113 Longwood ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Richardson

(a) RESIDENCE. No. 1113 Longwood ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred - 8 - mos. - ds. How long in U. S., if of foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of wife

6 DATE OF BIRTH (month, day, and year) Sept 16th 1875

7 AGE Years 46 Months 10 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

10 NAME OF FATHER John O Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Gynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14

Informant

(Address)

Mrs Anna Fort 1113 Longwood St

15

AUG 14 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/12 1922

17 I HEREBY CERTIFY, That I attended deceased from

8/12 1922, to 8/12 1922, that I last saw her alive on 8/12 1922,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Heart plegia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. Edema Lungs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? - Date of -

Was there an autopsy? -

What test confirmed diagnosis?

(Signed)

19 (Address)

H. O. Grant, M. D. 1207 Poplar Grove

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Peter's

Aug 14 1922

20 UNDERTAKER

ADDRESS

John Fields 1200 W Lombard

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Apoplectic hemiplegia

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

66770 HEALTH DEPARTMENT—CITY OF BALTIMORE 66770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4650 Fernwood St. 7th Ward)

Registered No. C.

2-FULL NAME

Martha Matthews

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 4650 Fernwood St. 35 years 11 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OF RACE White 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. 10/31/1853 (Month) (Day) (Year)

7-AGE. 68 yrs. 9 mos. 11 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housekeeper (b) General nature of industry, business, or establishment in which employed (employer).

9-BIRTHPLACE, (State or Country) Maryland

10-NAME OF FATHER Jos. Matthews

11-BIRTHPLACE OF FATHER, (State or Country) Baeto Co. Pa.

12-MAIDEN NAME OF MOTHER Sophia Hittner

13-BIRTHPLACE OF MOTHER, (State or Country) Carroll Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Wm. Eschro L. Matthews (Address) 337 Rosebank Ave.

15- AUG 14 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 14 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and found that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows: Acute dilatation of heart.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. H. Thompson, M.D. Coroner. 1922 Address 3632 Bladensburg

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Form of usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

New Powder, Aug 14, 1922

20-UNDERTAKER, ADDRESS.

William Cook 552 E North St.

Spec. - 1-10-21 M&T 1500 Bks.

66771 HEALTH DEPARTMENT—CITY OF BALTIMORE 66721
D 66771

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 Harford Ave. 10 WARD)

2-FULL NAME Sarah J. Mullan

(a) RESIDENCE NO. 836 Harford Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 11/1867

7 AGE Years 55 Months 12 Days LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER John Mullan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mullan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sarah J. Mullan (Address) 836 Harford Ave.

15 AUG 14 1922

ROBERT N. MAUTER, Registrar

66721 90 D 66771

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

16 DATE OF DEATH (month, day, and year) Aug 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1921, to Aug 12, 1922, that I last saw her alive on Aug 12, 1922, and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows: Ch. Myocarditis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hornstein M. D.

(Address) 733 Arguich St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT DATE OF BURIAL

20 ADDRESS

21

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 66772

CERTIFICATE OF DEATH.

113 D 66772

1-PLACE OF DEATH *University Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY *BALTIMORE*: (No. *9* ST.: *9* WARD)2-FULL NAME *Jacob Rosen*(a) RESIDENCE. NO. *1008 E. Preston*

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *XX* yrs. *4* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *May 6, 1922*7 AGE Years *XX* Months *4* Days *XX* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country) *Vol. of Amer. Hospital*10 NAME OF FATHER *Samuel Rosen*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Russia*12 MAIDEN NAME OF MOTHER *Amelia Stone*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Russia*

14

Informant

(Address) *Mother Rosen*

15

AUG 14 1922

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 10* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 9* 19 *22* to *Aug 10* 19 *22*that I last saw him alive on *Aug 10* 19 *22*and that death occurred, on the date stated above, at *8³⁰ A. m.*

The CAUSE OF DEATH* was as follows:

Acute Ills Colitis(duration) *XX* yrs. *XX* mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *at home* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *History + Stools*(Signed) *John E. Aubrey* M. D.8/13, 1922 (Address) *1629 St Paul St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebur Mt Carmel**Aug 14 1922*

20 UNDERTAKER

ADDRESS *1127**Mat Finson**E Balto*

Every item of information should be stated EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1560 Bks.

Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1560 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66773

D 66773

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Goldsborough

(a) RESIDENCE NO. Unknowns

ST., 76 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

Black

Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

About 50

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--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Unknown

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Hospital Records,

Municipal Hospital.

15

AUG 14 1922

ROBERT R. KRAUTER,

Bureau Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 19 22

17

I HEREBY CERTIFY, That I attended deceased from August 7, 19 22, to August 11, 19 22.

that I last saw him alive on August 11, 19 22.

and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Acute hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde W. Davis, M. D.

8/13/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Burnside Branch Co

Aug 15, 1922

20 UNDERTAKER

John F. Denny

ADDRESS

715 Light St

D 66774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *123 Warren Ave* ST.: *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary V. Cleft*(a) RESIDENCE. NO. *123 Warren Ave* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *75* yrs. *8* mos. *19* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

female white married

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Mark A. G. Cleft.*6 DATE OF BIRTH (month, day, and year) *Nov. 22-1846*

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*75**8**19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Thomas B Norfolk

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Ann Seward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

(Address)

*Mark A G Cleft**123 Warren Ave*

15

Filed

19

AUG 14 1922

ROBERT R. KRAUTER
Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 11th 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*march 19, 1927, to Aug 11th, 1922.*that I last saw her alive on *Aug 11th, 1922.*and that death occurred, on the date stated above, at *10-a* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

*Cerebral Hemorrhage -**Mar. 19-1917.* (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ☒Did an operation precede death? *no* Date of ☒Was there an autopsy? *no*What test confirmed diagnosis? ☒

(Signed)

E. E. Burton

M. D.

8/11, 1922 (Address)

301 E. Lassa.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Olivet Cemetery Aug 14 1922

20 UNDERTAKER

ADDRESS

*John F. Denny**715 Light St*

PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66775 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D 66775
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1400 N. Saratoga ST.: 19 WARD)

2-FULL NAME

Maria L. Rothrock

(a) RESIDENCE. NO.

1400 N. Saratoga ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

76 yrs. 3 mos. 24 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single~~, Married, Widowed,
or Divorced (write the word)

Female White

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Joseph W. Rothrock

6 DATE OF BIRTH (month, day, and year)

April 19, 1846

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

76

3

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housewife

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

Henry E. Huber

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Baltimore
Maryland

12 MAIDEN NAME OF MOTHER

Susan Robinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore
Maryland

14

Informant
(Address)Joseph W. Rothrock
1400 N. Saratoga St.

AUG 14 1922

ROBERT R. KRAUTER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 1922, to Aug 13, 1922.

that I last saw him alive on Aug 12, 1922.

and that death occurred, on the date stated above, at 10:45 A. M.

The CAUSE OF DEATH* was as follows:

Uremic Coma

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. M. J. Oram M. D.

AUG 14 1922 19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

20 UNDERTAKER

Geo W Little

DATE OF BURIAL

AUG 16 1922

ADDRESS

2700

EDMONSON AVE.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.
Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 66776

66776

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. Joseph's Hospital*
CITY OF BALTIMORE: (No. *Caroline & Hoffman* ST., *9* WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Barbara Goodine*
(a) RESIDENCE NO. *St. Joseph's Hospital* ST., _____ WARD _____
(Usual place of abode)
Length of residence in city or town where death occurred *2* yrs. *2* mos. _____ ds. How long in U. S., if of foreign birth? *2* yrs. *2* mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) *Not known*
7 AGE *54* Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Nurse (trained)*
(b) General nature of industry, business, or establishment in which employed (or employer) *48*
(c) Name of employer _____

9 BIRTHPLACE (city or town) *Canada* (State or country)

10 NAME OF FATHER *Michael Gooding*

11 BIRTHPLACE OF FATHER (city or town) *Not known* (State or country)

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town) *Not known* (State or country)

14 Informant *Hospital Records* (Address) *Caroline & Hoffman*

15 *AUG 14 1922* *ROBERT R. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 12, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Aug. 11, 1922*, to *Aug. 12, 1922*, that I last saw her alive on *Aug. 12, 1922*, and that death occurred, on the date stated above, at *5:45 P. M.*

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency

(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY *Diabetes mellitus*
(Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? *no* Date of _____

Was there an autopsy? *no*

What test confirmed diagnosis? *P.S. & S.*
(Signed) *J. A. Schmitt*, M. D.
, 19 _____ (Address) *St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Redeemer Cemetery* DATE OF BURIAL *Aug. 15, 1922*

20 UNDERTAKER *Henry Hock Sun* ADDRESS *130, E. Bay St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66777

74-001
D 66777

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor* ST. *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Clara Trelost*(a) RESIDENCE. NO. *Preston Valley* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Single*6 DATE OF BIRTH (month, day, and year) *25 March 1836*7 AGE Years *86* Months *5* Days *18* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None off*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Mo.*10 NAME OF FATHER *Aime Trelost*11 BIRTHPLACE OF FATHER (city or town) (State or country) *San Dominguito*12 MAIDEN NAME OF MOTHER *Julie Serchany*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *San Domingo*14 Informant *Sister Florence* (Address) *Preston Valley*15 *AUG 14 1922* *ROBERT R. KRAUTER* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 12 1922*17 I HEREBY CERTIFY, That I attended deceased from *No record* 19 to 19that I last saw h *or* alive on *Aug 11* 1922and that death occurred, on the date stated above, at *1 p. m.*

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. A. Warner* M. D.19 22 Address) *1133 Valley St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Aug 14 1922

20 UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Green

Every item of information should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Reservoir St. ST. 13 WARD)

2-FULL NAME

Charles F. Harmon

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

603 Reservoir St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

4

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteMarried

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofAlice L. Harmon6 DATE OF BIRTH (month, day, and year) Oct. 15 1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.64927

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk-Treasury

(b) General nature of industry, business, or establishment in which employed (or employer)

Dept. U. S.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Portland, ME
Maine

10 NAME OF FATHER

John Harmon11 BIRTHPLACE OF FATHER (city or town)
(State or country)Portland
Maine

12 MAIDEN NAME OF MOTHER

Mary Foss13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Portland
Maine

14

Informant

Mrs. Alice Harmon

(Address)

603 Reservoir St.AUG 14 1922ROBERT R. KRAUTER
Registrar

Burial Permit Check

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 1922

17

I HEREBY CERTIFY, That I attended deceased from
Aug 8, 1922, to Aug 11, 1922,
that last saw him alive on Aug 11, 1922,and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the
liver

(duration)

yrs. 6

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs. 1

mos.

ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Wm. Beal, M. D.

3/12/22 (Address)

Arundel Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

Joseph B. CookAug 14 1922
603 R. Reservoir St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66779

CERTIFICATE OF DEATH.

Registered No. C

D 66779

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins* St., *15* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1340 N. Monmouth* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Black* 5-~~Single~~ *Married* Widowed, or Divorced (Write the word.)

6-DATE OF BIRTH *January 4, 1922* (Month) (Day) (Year)

7-AGE *1* yrs. *7* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) *Balto Md*

10-NAME OF FATHER *Ray E. Nicholson*

11-BIRTHPLACE OF FATHER, (State or Country) *Wrentham Co*

12-MAIDEN NAME OF MOTHER *Lillian Thomas*

13-BIRTHPLACE OF MOTHER, (State or Country) *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Bernice Myers*

(Address) *1340 N Monmouth*

15-AUG 14 1922

ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 12, 1922* (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stroke

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Operative strangulation*

(Signed) *J. H. Packer* M. D.

(Coroner) *August 12, 1922* (Address) *508 E. Pratt Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

mt auburn *Aug 14 1922*

20-UNDERTAKER. ADDRESS

Joseph A. Farrell *230 Biddle St*

Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION. AGE should be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66780

CERTIFICATE OF DEATH.

113 D 66780

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3424 Levertown Ave ST., 76 WARD)

2-FULL NAME

Raymond O. Deacon

(a) RESIDENCE NO.

(Usual place of abode)

3424 Levertown Ave ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2-21

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 2 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER John O. Deacon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary C. Smidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) John O. Deacon 3424 Levertown Ave

15

AUG 14 1922

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 19 22, to Aug 12, 19 22, that I last saw him alive on Aug 12, 19 22, and that death occurred, on the date stated above, at 9:35 a.m.

The CAUSE OF DEATH* was as follows:
Auto Intoxication
(duration) yrs. mos. ds. 1
CONTRIBUTORY Gastro Intoxication
(Secondary) (duration) yrs. mos. ds. 9

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. S. Sudler, M. D.

(Address) 3323 E. Calver St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto. Cem.

DATE OF BURIAL

8/14 1922

20 UNDERTAKER

Philip Herwig

ADDRESS

2016 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 N. Lammah ST.; 11 WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 231 N. Lammah St.; 90 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Oct 24, 1832
(Month) (Day) (Year)

7-AGE,

89 yrs., 9 mos., 6 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer) House work at home

9-BIRTHPLACE, (State or Country),

Balto Md.

10-NAME OF FATHER,

Columbus J. Stewart

11-BIRTHPLACE OF FATHER (State or Country),

Washington D.C.

12-MAIDEN NAME OF MOTHER

Mary E. Wible

13-BIRTHPLACE OF MOTHER (State or Country),

Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Stewart Hopkins(Address) 231 N. Lammah St.

15-

AUG 14 1922
ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 12, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan 30 1922, to Aug 12 1922,that I saw her alive on Aug 5, 1922,and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs
Amie(Duration) 3 yrs., 3 mos., ds.CONTRIBUTORY (Secondary) In bed 3 mos.(Duration) yrs., mos., ds.(Signed) J. S. Hopkins M. D.101... (Address) 231 N. Lammah St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Olivet Cemetery

DATE OF BURIAL,

8/14, 1922

20-UNDERTAKER

W. H. Routson

ADDRESS

2238 N. Mt.

Physicians should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66782

D 66782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hehrem Hosh* ST. *2* WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Samuel Abrahamson*(a) RESIDENCE. No. *1912 E Baltimore* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds.How long in U. S., if of foreign birth? *10* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

*White*5 Single, ~~Married~~, Widowed, or Divorced (write the word)*Married*5a If ~~married~~ widowed, or divorced

HUSBAND of (or) WIFE of

*Rebecca Abrahamson*6 DATE OF BIRTH (month, day, and year) *Aug 6 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Dealer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Isidor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Isidor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E Baltimore St

15

File

AUG 14 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8/13 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Aug 6 1922, to Aug 13 1922*that I last saw him alive on *Aug 13 1922*and that death occurred, on the date stated above, at *99* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Uremia(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Urine, a Blood tests*(Signed) *I Irvin Levy*, M. D.*8/13 1922* (Address) *Hebrew Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hehrem Hosh Road**8/14 1922*

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E Baltimore St

Every item of information should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T-1500 Bks. D 66783 157656 HEALTH DEPARTMENT-CITY OF BALTIMORE CERTIFICATE OF DEATH. X 100-001

Every item of information should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T-1500 Bks.

D 66783

157656

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66783

1-PLACE OF DEATH

CITY OF BALTIMORE: (N) JOHNS HOPKINS HOSPITAL 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lestie Happer

(a) RESIDENCE NO. 835 North Side Sparrows Point ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
or WIFE of

Moses Happer, father

6 DATE OF BIRTH (month, day, and year) June 9, 1900

7 AGE 22 Years 2 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Plant Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer 086

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Moses Happer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucie Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant JOHNS HOPKINS HOSPITAL (Address) 1101

15 Filed 19 H. Wehm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1922 to Aug 11, 1922, that I last saw him alive on Aug 11, 1922, and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy (Signed) Myron E. Gledits, M. D.

, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Richmond Va Aug 19, 1922

20 UNDERTAKER John H. Toadon 142

Spec.—1-10-21—M&T—1500 Bks.

Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 S Chester ST., 2 WARD)

2. FULL NAME Eugene D Kotawski

(a) RESIDENCE NO. 414 S Chester

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18 1922

7 AGE Years Months Days If LESS than 1 day, hrs or min. 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Stanley Kotawski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Anna Dubiel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Stanley Kotawski (Address) 414 S Chester St

15 Filed AUG 14 1922 J. W. Chen Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Friday, 19 22, to Sunday 13, 19 22, that I last saw him alive on 13, 19 22, and that death occurred, on the date stated above, at 12:00 p.m.

The CAUSE OF DEATH* was as follows:

Acute myocardial
caused by improper oral
feeding
(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Improper feeding
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel S. Fisher, M. D.

, 19 (Address) 3520 Park Pl Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Rosary Aug 14 1922

20 UNDERTAKER

ADDRESS

John Mawcher 1803 Bank

Spec. - 1-10-21 - M&T - 1500 Bks.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

D 66785

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1505 Nelson's bt.* ST. *3* WARD)

2-FULL NAME

Adam Bilski

(a) RESIDENCE NO. *1505 Nelson's bt.* ST. *3* WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

10 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

white

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 4 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Frank Bilski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Agatha Bayard

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Frank Bilski 1505 Nelson's bt.

15

AUG 14 1922

J. W. Weber

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 13 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 12 1922 to *Aug. 13 1922*

that I last saw him alive on *Aug. 13 1922*

and that death occurred, on the date stated above, at *7 P.* m.

The CAUSE OF DEATH* was as follows:

Infantile

(duration)

yrs.

mos.

10 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no*

Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

John H. Rehder M. D.

19

(Address) *1709 Allen Avenue*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Italy Rosary Aug 14 1922

20 UNDERTAKER

ADDRESS

Lohn m. Weber 1803 Bank

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66786

CERTIFICATE OF DEATH.

D 66786

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Morrow Hospital* ST. *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*81**?**?*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

Iron worker

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

George T. O'Hare
3815 Roland Ave

15

AUG 14 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/12 1922

17

I HEREBY CERTIFY, That I attended deceased from

*6/6 1922, to 8/12 1922,*that I last saw him live on *8/12 1922*and that death occurred, on the date stated above, at *2:46* m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
Chronic Nephritis(duration) *1* yrs. *10* mos. ds.

CONTRIBUTORY (Secondary)

Uremia(duration) *3* yrs. *3* mos. ds.

18 Where was disease contracted

if not at place of death? *Unknown*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *P E Scholz*, M. D., 19 (Address) *Morrow Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Aug 15 1922

20 UNDERTAKER

ADDRESS

Chenoweth & Son Chestnut St

Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 66787

Rounelis
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66787

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *26* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

4607 Eastern ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

June 12, 1922 to Aug 12, 1922 that I last saw alive on Aug 12, 1922

and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1749 Ashland Ave 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Small(a) RESIDENCE NO. 1749 Ashland Ave 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word)5a If married, widowed, or divorced
HUSBAND or
(or) WIFE of Leon Small6 DATE OF BIRTH (month, day, and year) Aug 14 19027 AGE 39 yrs Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Magdaly A. G. Co.
(State or country) Ind10 NAME OF FATHER Richard Green11 BIRTHPLACE OF FATHER (city or town) Magdaly
(State or country) A. G. Co. Ind12 MAIDEN NAME OF MOTHER Sarah Horrie13 BIRTHPLACE OF MOTHER (city or town) Magdaly
(State or country) A. G. Co. Ind14 Informant Leon Small
(Address) 1749 Ashland Ave15 Filed AUG 14 1922 J. H. W. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13-192217 I HEREBY CERTIFY, That I attended deceased from 5-2-1922 to 8-13-1922, that I last saw her alive on 8-12-1922, and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Chronic ValvulitisCONTRIBUTORY
(Secondary)(duration) Indefinite yrs. mos. ds.(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Cargill, M. D.8-13-1922 (Address) 611-21-1 Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Magdaly A. G. Co. Ind 8/17 1922

20 UNDERTAKER

ADDRESS

Jac. H. Skinner 1221 E. Mad. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

D 66789

1-PLACE OF DEATH D 66789

CITY OF BALTIMORE: (No. 728 Wyndhurst Ave ST. 71 WARD)

2-FULL NAME Deceased of Robert W. May C. Mueser

(a) RESIDENCE. NO. 728 Wyndhurst Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Robert W. Mueser

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER May C. Charles

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 AUG 14 1922

ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1922, to Aug 10, 1922,

that I last saw him alive on Aug 10, 1922, and that death occurred, on the date stated above, at 11:20 P.M.

The CAUSE OF DEATH* was as follows:

Apnea Neonatorum

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) R. B. Vornum M. D.

P. M. 1922 Address 7347 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 435 W. Conway ST., 22 WARD)

2-FULL NAME

Wm Henry Golder, Jr

(a) RESIDENCE NO.

435 W. Conway ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

✓

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

0

0

0

1 day

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

✓

(b) General nature of industry, business, or establishment in which employed (or employer)

✓

(c) Name of employer

✓

9 BIRTHPLACE (city or town) (State or country)

Balto. Md
usa

10 NAME OF FATHER

Wm H Golder

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Edith M. Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cambridge
Md.

14

Informant (Address)

JOHN HOPKINS HOSPITAL

15

AUG 14 1922

ROBERT N. KRAUER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1922, to Aug 11, 1922, that I last saw him alive on Aug 10, 1922, and that death occurred, on the date stated above, at 12:10 P. m. The CAUSE OF DEATH* was as follows:

Congenital Valvular
Disease of Heart
(Pulmonary Stenosis)

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

✓

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical signs only

(Signed)

D. H. Canwell M. D.

(Address)

1400 Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

19

ADDRESS

AUG 14 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1504 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66791 CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *13 E. Franklin St.* ST. WARD) 4

2-FULL NAME

(a) RESIDENCE No. *13 E. Franklin St.* ST. WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Boy.

4 COLOR OR RACE

White.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 9 '1922*

7 AGE

Years

Months

Days

If LESS than 1 day, *7* hrs. or *—* min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore, Md.*

10 NAME OF FATHER *Frank Hauld*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore, Md.*

12 MAIDEN NAME OF MOTHER *Alice Hauld*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Philadelphia, Pa.*

14

Informant

AUG 14 1922

Filed

19

ROBERT A. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 9 '22*

17

I HEREBY CERTIFY, That I attended deceased from

Aug 9 '22, to *Aug 9 '22*,

19*22*.

that I last saw him alive on

Aug 9 '22, 19*22*.

and that death occurred, on the date stated above, at

9 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration)

yrs.

mos.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *180*

Was there an autopsy? *No*

What test confirmed diagnosis? *Sputum & Serum*

(Signed) *J. B. Squire*

M. D.

, 19 (Address) *13 E. Franklin St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Body at city morgue
HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH **66792** **CERTIFICATE OF DEATH.**

Registered No. C 66792

1-PLACE OF DEATH _____ Registered No. C. _____
 City of BALTIMORE: (No. 5-31 S Pac a st St. 22 Ward) (If death occurred in a
 hospital or institution,
 give its NAME instead
 of street and number and
 fill out No. 18.)
 2-FULL NAME Jimmie M. Coleman
Rock Hall Md
 (Residence in Baltimore: No. _____ St.; yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

CORONER'S CERTIFICATE OF DEATH.

3-SEX, <i>male</i>	4-COLOR OR RACE, <i>W</i>	5-Single, Married, Widowed, or Divorced, (Write the word.) <i>Married</i>
6-DATE OF BIRTH, <i>Don't Know</i>	(Month)	(Day) (Year)

16-DATE OF DEATH, Aug 5 1928
(Month) (Day) (Year)

3-AGE. 5-10 yrs. 100 mgs. 1 ds. If LESS than 1 day, 1 hrs. or 1 min. ⁹

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest au- topsy or inquiry.) find that said deceased came to his death on the day stated above.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work..... *Sailor*

(b) General nature of industry, business, or establishment in which employed (or employer)..... *886*

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

9-BIRTHPLACE.
(State or Country), OKLAHOMA

(Duration) Ex 001/1m

10-NAME OF FATHER,	Charles W. ...
--------------------	----------------

CONTRIBUTORY *Don't Know*
(Secondary)

11. BIRTHPLACE
OF FATHER.
(State or Country).

..... (Duration) yrs..... mos✓ ds

12-MAIDEN NAME OF MOTHER, *Don't know*

(Signed) W. J. Jones M. D.
(Coroner.)

13-BIRTHPLACE
OF MOTHER,
(State or Country),

8-7 1922 (Address) 117 W. Naudy St.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

11-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

(Informant) Rose E. Coleman
(Address) 107 S. Penn St.

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds

Where was disease contracted, If not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

15. _____ UNIV

PROPERTY OF MARVIN AND

Filed 192 AUG 14 1977 ROBERT A. KRAUTER

UNIVERSITY OF MARYLAND..... 10.....

90-UNDERTAKER	ADDRESS
---------------	---------

... .. 206

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66793

CERTIFICATE OF DEATH.

90 D 66793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 W. York ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Carrie Ward

(a) RESIDENCE NO.

103 W. York

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

? yrs.

? mos.

? ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fe.

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

William Ward

6 DATE OF BIRTH (month, day, and year)

Feb. 29 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

46

5

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Oyster Shucker

(b) General nature of industry, business, or establishment in which employed (or employer)

Oyster Industry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cambridge, Ms

10 NAME OF FATHER

Frank Truitt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cambridge

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cambridge

14

Informant

Richard Ward

(Address)

103 W. York St.

15

AUG 14 1922

ROBERT R. KRAUTER

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 10th, 1922, to Aug 12th, 1922.

that I last saw her alive on Aug 12, 1922.

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease
(Aortic Insufficiency)

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

L

Did an operation precede death? No Date of L

Was there an autopsy? No

What test confirmed diagnosis? only clinical signs

(Signed) D. H. Russell, M. D.

714, 1922 (Address) 140 W. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL
W. Auburn St

Aug 15 1922

20 UNDERTAKER

ADDRESS

L. E. Brown & Son

1314 W. Hill St.

D 66794

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66794

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2134 Bolton

ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Samuel Mustard Perry

(a) RESIDENCE. NO.

2134 Bolton

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 9 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Alice Perry

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
82		11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Minister (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cockeysville, Md.

10 NAME OF FATHER

William Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cockeysville, Md.

12 MAIDEN NAME OF MOTHER

Lidia Mustard

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cockeysville, Md.

PARENTS

14 Informant (Address)

Mrs. Howard Shufly, 2134 Bolton St.

Robert F. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1922

17 I HEREBY CERTIFY, That I attended deceased from

Dec 14 1917, to Aug 12 1922

that I last saw him alive on Aug 6 1922

and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, (with large blood pressure)

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cerebral Apoplexy (duration) 1 minute yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Robert F. Harrison, M. D.

Aug 13 1922 (Address) 2134 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Smyrna, Del.

Aug 15 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 12016, Fayette St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 14 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66795

CERTIFICATE OF DEATH.

90 D 66795

1-PLACE OF DEATH

CITY OF BALTIMORE: *2215 N Charles* ST., *12* WARD)

2-FULL NAME

(a) RESIDENCE No. *2215 N Charles* ST., *12* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *12* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed or divorced HUSBAND of *Emma Ellis* or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 23. 1842*

7 AGE *80* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired Hospital Supt*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)

10 NAME OF FATHER *John Ellis*

11 BIRTHPLACE OF FATHER (city or town) *MD* (State or country)

12 MAIDEN NAME OF MOTHER *Elizabeth Dyer*

13 BIRTHPLACE OF MOTHER (city or town) *MD* (State or country)

14 Informant *Minnie F. Ellis* (Address) *2215 N Charles St*

15 *14* 1922

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 13* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from *1916* to *August 13* 19 *22*.

that I last saw him alive on *August 13* 19 *22*.

and that death occurred, on the date stated above, at *1215 P* m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) *7* yrs. mos. ds.

CONTRIBUTORY *Cardiac decompensation* (Secondary)

(duration) *3* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Usual chemical tests*

(Signed) *George M. Ellis* M. D.

Aug 13 19 22 Address *2430 Maryland Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Mount Aug 16 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 1201 W. Fayette

D 66796

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66796

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2 E. Montgomery* ST. *22* WARD)2-FULL NAME *Edgar M. Englemeyer*(a) RESIDENCE. NO. *2 E. Montgomery* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *1* yrs. *4* mos. *13* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 12*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 *4* *13*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *John M. Englemeyer*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Mellie January*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 13* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 13*, 19*22*, to *Aug 13*, 19*22*that I last saw him live on *Aug 13*, 19*22*,and that death occurred, on the date stated above, at *11* m.

The CAUSE OF DEATH* was as follows:

*Laryngeal diphtheria*CONTRIBUTORY (Secondary) *Exhaustion* (duration) yrs. mos. *3* ds.(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *No*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. P. Harrison* M. D. *Aug 22* (Address) *1644 Haverwood Dr*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer**Aug 14* 19*22*

20 UNDERTAKER

ADDRESS

F. A. Krause & Son 2031 Howard

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JG 14 1922

Bureau Permit Clerk

CB-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66797 49 D 66797

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3049 Stopped St. 20 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.. David M. Gloag

(Residence in Baltimore: No. 3049 Stopped St.; yrs. 38 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Oct 14 1887 (Month) (Day) (Year)

7-AGE, 54 yrs. 9 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Hair worker (b) General nature of industry, business, or establishment in which employed (or employer) Wilkerson Hat Factory

9-BIRTHPLACE, (State or Country), Scotland

10-NAME OF FATHER, John Gloag

11-BIRTHPLACE OF FATHER, (State or Country), Scotland

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gloag

(Address) 3049 Stopped St.

15- Robert P. Harrison, Registrar. File 141922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 13 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Lymphatic Carcinoma following Epithelioma neck (Duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) James M. Keaton M. D. (Coroner.) Aug 14 1922 (Address) 700 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Western Cemetery Aug 16 1922

20-UNDERTAKER, ADDRESS, D. Mappert 236 Fresh W

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66798

D 66798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 332 Maryland Ave. Westport ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Wiegand(a) RESIDENCE NO. 332 Maryland Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Walter Wiegand6 DATE OF BIRTH (month, day, and year) Oct. 13 18717 AGE Years 50 Months 10 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER John Butz11 BIRTHPLACE OF FATHER (city or town) Saxony (State or country) Germany12 MAIDEN NAME OF MOTHER Dorthea Waxmuth13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14

Informant Walter Wiegand (Address) 332 Maryland Ave. Westport

15

Robert F. Harrison,

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13 1922

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1922, to Aug 13, 1922, that I last saw her alive on Aug 12, 1922, and that death occurred, on the date stated above, at 3.15 A. M.

The CAUSE OF DEATH* was as follows:

Acute suppurative(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical ex.(Signed) J. M. Lempert, M. D.6/14/22 (Address) 826 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE- MOVAL

Western Cemetery Aug 16 1922

20 UNDERTAKER

Joseph B. Cook 1003 N. Falls

B. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

14 1922

D 66799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32-D 66799

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3027 Frederick St WARD 14)2-FULL NAME Roland, N. Carter(a) RESIDENCE NO. 3027 Frederick St WARD 14

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28 19217 AGE Years 1 Months 6 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Albert L. Carter11 BIRTHPLACE OF FATHER (city or town) (State or country) Na12 MAIDEN NAME OF MOTHER Ella M. Evans13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore14 Informant (Address) Albert L. Carter
3027 Frederick St15 Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 192217 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1922, to Aug 14, 1922, that I last saw him live on Aug 13, 1922, and that death occurred, on the date stated above, at 1:30 m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Smear, Papanicolaou(Signed) Howard W. Jones, M. D.8-14-22 (Address) Baltimore

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

For Jorden's Son 217 S. P.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

114 1922

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66800

CERTIFICATE OF DEATH.

90 D 66800

PLACE OF DEATH

CITY OF BALTIMORE (No. *1121 Harford Ave* St. *10* WARD)

2-FULL NAME *Aubrey Dennis*

(Residence in Baltimore: No. *1121 Harford Ave.*

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. *5* yrs., *5* mos. *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male*

4-COLOR OR RACE, *White*

5-SINGLE, *Married*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH, *Feb 25*, *1886*

7-AGE, *36* yrs., *5* mos., *12* ds.

If LESS than 1 day,
...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Blacksmith*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Madison County Va*

10-NAME OF FATHER, *James M. Dennis*

11-BIRTHPLACE OF FATHER, (State or Country), *Madison County Va*

12-MAIDEN NAME OF MOTHER, *Julia Berrie*

13-BIRTHPLACE OF MOTHER, (State or Country), *Madison County Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ella Dennis*

(Address) *1121 Harford Ave*

15-

Robert F. Harrison

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 13*, *1922*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held no *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*, *autopsy* find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Lesion (Probably
Embolic character)
(Duration) *5* yrs., *5* mos., *5* ds.

CONTRIBUTORY (Secondary) *Rheumatism*

(Signed) *J. H. Potter* M. D.
(Coroner.)

Aug 14 1922 (Address) *S. O. S. C. N. on the*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the of death *5* yrs., *5* mos., *5* ds. State *5* yrs., *5* mos., *5* ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cem*

DATE OF BURIAL, *Aug 15 1922*

20-UNDERTAKER, *Has C Miller*

ADDRESS, *2334 Jefferson St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66801

CERTIFICATE OF DEATH.

113 D 66801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 S 15 ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George S. Sikalis

(a) RESIDENCE NO.

404 S 15

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Mont

Days

If LESS than 1 day, hrs. or min.

4 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Lewis Sikalis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Greece

12 MAIDEN NAME OF MOTHER

Mathe Lamara

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Greece

14

Informant (Address)

Lewis Sikalis
414 S 15

15

And

19

1922

Registrar

Notary Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 14 1922

17

I HEREBY CERTIFY That I attended deceased from

Aug 12, 1922, to Aug 14, 1922.

that I last saw him alive on Aug 13, 1922.

and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

404 S 15

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) A. W. Schuler, M. D.

1922 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA Aug 15 1922

20 UNDERTAKER

ADDRESS

William Cook 502 N. 1st

Spec. - 1-10-21 - M&T - 1500 Bks.

001
161

D 66802

HEALTH DEPARTMENT—CITY OF BALTIMORE

161

001

D 66802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. V. Inf. Asy.*

CITY OF BALTIMORE: (No. *1401* *20* *Division* *ST 14* WARD)

2-FULL NAME *Elizabeth Ann Chappel*

(a) RESIDENCE NO. *1401-Division* ST., _____ WARD _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. *5* mos. *28* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *None*

6 DATE OF BIRTH (month, day, and year) *Feb. 18 - 1922*

7 AGE Years _____ Months *5* Days *28* If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer) *None*

(c) Name of employer *None*

9 BIRTHPLACE (city or town) (State or country) *Balto Md.*

10 NAME OF FATHER *Not known*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md.*

12 MAIDEN NAME OF MOTHER *Marie Chappel*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md.*

14 Informant (Address) *St Vincent Inf Asy*

15 Filed *Robert P. Harrison,* Registrar

16 DATE OF DEATH (month, day, and year) *Aug. 11 1922*

17 I HEREBY CERTIFY, That I attended deceased from *May 1*, 1922, to *Aug. 11*, 1922, that I last saw her alive on *Aug 11*, 1922, and that death occurred, on the date stated above at *11:30 P* m. The CAUSE OF DEATH* was as follows:

Premature (7 mos)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) *Malnutrition* (duration) _____ yrs. *5* mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) *Chas. R. Goodenough*, M. D.

, 19 (Address) *2735 N. Charles St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Redeemer*

20 UNDERTAKER *Martin Trahey*

DATE OF BURIAL *Aug. 15 1922*

ADDITIONAL INFORMATION *1827 N. York*

14 1922

BURIAL PERMIT CLERK

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66804

113 D 66804

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 Clarkson ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Catherine Bures

(a) RESIDENCE NO.

1721 Clarkson

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

6

mos.

14

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 29 1922

7 AGE

Years

Months

Days

614

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Grason W Bures

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Lucy C White

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant (Address)

Mr Grason W Bures 1721 Clarkson St

15

Robert F. Harris

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 6 1922 to Aug 13 1922that I last saw him alive on Aug 12 1922and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy?

What test confirmed diagnosis?

Phys. Campbell1922 (Address) 1644 Hillwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Baltimore Cemetery

20 UNDERTAKER

John F Denny

DATE OF BURIAL

Aug 15 1922

ADDRESS

715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *406 Annapolis Ave.*, ST.: *Brooklyn* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *406 Annapolis Ave* ST.: *Brooklyn* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 25/1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*5**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

(Brooklyn) Md

10 NAME OF FATHER

Howard Schline

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Brooklyn Md

12 MAIDEN NAME OF MOTHER

Mellissa P Tawes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant *Mrs Mellissa P Schline*(Address) *406 Annapolis Ave Brooklyn*

15

Filed *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 14* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

Aug 8 19*22*, to *Aug 14* 19*22*that I last saw him alive on *Aug 14* 19*22*and that death occurred, on the date stated above, at *10:20 a.m.*The CAUSE OF DEATH* was *as follows:**Toxemia, Acute, Dietetic (Condensed Milk)*(duration) yrs. mos. ds. *15* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Same

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Robert W. Johnson* M. D.19 (Address) *Brooklyn Md*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill

DATE OF BURIAL

Aug 16 1922

20 UNDERTAKER

John F. Denny

ADDRESS

715 Light

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG 14 1922

Burial Permit Clerk.

UNDERTAKER,	ADDRESS
Geo. G. Crook	North Harbor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 66808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 179.D 66808

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Baker

(a) RESIDENCE NO. Unknown

ST. 76 WARD 76

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1845

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

77

--

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8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

France

10 NAME OF FATHER Frank Baker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

France

12 MAIDEN NAME OF MOTHER Armadio Rosina

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

France

14

Informant (Address)

Hospital Records, Municipal Hospital.

15

AUG 15 1922

ROBERT N. MAUTER,
Registrar

Barla Parmiti Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13th 22

17

I HEREBY CERTIFY, That I attended deceased from August 11, 1922 to August 13, 1922.

that I last saw him alive on August 13, 1922.

and that death occurred, on the date stated above, at 6:30 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

6/14/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Secret Heart

Aug 15 1922

20 UNDERTAKER

ADDRESS

FUNERAL DIRECTORS

1635 W. 11th STREET.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66809

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1621 Bruce St.)

2-FULL NAME

(Residence in Baltimore: No. 1621 Bruce St.)

ST. 15 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. (yrs., 15) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Widower

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

38 yrs. - mos. - ds.

If LESS than 1 day,

...hrs. or ...mins.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... (b) General nature of industry, business, or establishment in which employed (or employer)...

Labr

9-BIRTHPLACE,

(State or Country),

Va

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Carrie H. Henshaw
1621 Bruce St.

15-

AUG 15 1922

ROBERT N. MAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 12, 1922

17-I HEREBY CERTIFY, that I took charge of the remains described above, held and buried (Inquest and autopsy or inquest) thereon and from the evidence obtained by and from (Inquest and autopsy or inquest) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(Signed) J. H. Henshaw M. D.

(Coroner) 1912 Address 1632 Potomac

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

Edward Piggott 1463 Carey St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

15700810

HEALTH DEPARTMENT—CITY OF BALTIMORE

66810
91-007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Andrew Hall

(a) RESIDENCE No. 1440 Prestman ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

?

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Attie Hall

6 DATE OF BIRTH (month, day, and year)

Feb 2-1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

6

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Iron worker

(b) General nature of industry, business, or establishment in which employed (or employer)

OSB

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Sandy Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Mirra Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

AUG 15 1922

ROBERT R. KRAUTER

Registrar

Public Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 19 22

17

I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1922, to Aug 13th, 1922, that I last saw him alive on Aug 13th, 1922, and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Fangrene left foot

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 7, 1922

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) P B Mac Crudy, M. D.

, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

mt alburn

20 UNDERTAKER

Edward Bryon

DATE OF BURIAL

Aug 16 1922

ADDRESS 1631

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Not traumatic
Not diabetic
Arterio Sclerotic
No other abnormal condition

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 6681E

PLACE OF DEATH

CITY OF BALTIMORE (No. 1701 E Beadle ST. 8 WARD)

2-FULL NAME

Hyman Thompson

(Residence in Baltimore: No. 1631 - 7th St. N. W. Washington D.C. St.; yrs., mos. / ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

unknown

(Month)

(Day)

(Year)

7-AGE,

41

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Sailor

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jack Lewis

(Address)

1439 E. Balto St

15 AUG 15 1922

ROBERT H. MAUTER,

Bureau Permit Clerk,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 13, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Indigestion

(Duration) yrs. mos. ds.

(Signed) J. S. Water M. D.

(Coroner.)

Aug 14, 1922 (Address) 108 E. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Wash DC

DATE OF BURIAL,

8-15, 1922

20-UNDERTAKER

Jack Lewis 1439 E. Balto St

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66812

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Notre Dame Convent* ST.; *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary Patricia Rush*(Residence in Baltimore: No. *9 W. Mulberry St* St.; *30* yrs., *3* mos., *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
~~MARRIED,~~
~~WIDOWED,~~
~~OR DIVORCED,~~
(Write the word.)6-DATE OF BIRTH, *December 28*, *1851*
(Month) (Day) (Year)7-AGE, *70* yrs., *7* mos., *16* ds. If LESS than 1 day,
...hrs. or ...min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Domestic Work*
(b) General nature of industry, business, or establishment in which employed (or employer) *870*9-BIRTHPLACE, (State or Country), *Ireland*10-NAME OF FATHER, *Patrick Rush*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Catherine Owens*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sister Mary Dioneda*(Address) *Notre Dame, Annapolis St.*

AUG 15 1922

Filed....., 191.....

ROBERT R. KRAUTER,

Baltimore Health Officer

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 13*, *1922*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 11* 1922, to *Aug 12* 1922, that I saw her alive on *Aug 12* 1922, and that death occurred, on the date stated above, at.....m.The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY *Pernicious Anemia*
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *William R. Broughton* M. D.*Aug 14*, 1922 (Address) *213 E. Preston St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Goventown Private Cem *Aug 16*, 1922

20-UNDERTAKER ADDRESS

Frank A. Pink *915 N. Gay St*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. — WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D 66813

D 66813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 N. Central Ave. ST., 5 WARD)

2-FULL NAME

Lottie Holmes

(a) RESIDENCE NO.

503 N. Central Ave. ST., 5 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds.

How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Robert Holmes

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

general domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

John Gynn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Louis Gynn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

Robert Holmes
503 N. Central Ave.

15

AUG 15 1922

ROBERT R. NEAL
Health Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from

May 30, 1922 to Aug 13, 1922

that I last saw her alive on Aug 13, 1922

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. R. Robinson, M. D.

, 19 (Address) 1208 Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Asbury
John W. Henderson

DATE OF BURIAL

Aug 14, 1922

ADDRESS

1502 E. Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66814

66814

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1620 Clarkson St. St. 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME

Sophia Weikert.

69 -- 5 -- 19.

1620 Clarkson St.

St.; yrs., mos., ds.)

(Residence in Baltimore: No.....)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Widowed, Married, or Divorced, (Write the word.)

6-DATE OF BIRTH, February 24, 1853. (Month) (Day) (Year)

7-AGE, 69 yrs. 5 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, George Seebo.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Sophia Ackman.

13-BIRTHPLACE OF MOTHER, (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mary Appel. (daughter).

(Address), 1620 Clarkson St.

15- AUG 15 1922

Filed, 1922 Registrar, J. H. Kehm

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 12th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto H. Reinhardt M. D. (Coroner)

Aug. 14, 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

20-UNDERTAKER, ADDRESS.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66815

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4818 1st Ave Canton WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

William J. Beil

(a) RESIDENCE NO.

4818 1st Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Marion J. Beil

6 DATE OF BIRTH (month, day, and year)

Feb. 16, 1883

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

5

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore M. d.

10 NAME OF FATHER

Jacob Beil

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Annie M. Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

Marion J. Beil

(Address)

4818 1st Ave Canton

15

AUG 15 1922

J. Sander

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 12 1919, to Aug 12 1922.

that I last saw him alive on Aug 12 1922.

and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Military Service U.S.A.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) A. H. B. M.D. M. D.

Aug 14 1922 (Address) 805 Patterson St. A.V.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cem. Aug 15 1922

20 UNDERTAKER

J. Sander Sauer 1710 Med.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66816
Spec. 6-9-19 U. S. G. 1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66816

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 Myrtle St. ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bessie Poulson

(a) RESIDENCE. No.

212 Myrtle ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE col 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/1/1881

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 40 - 8 - 15 -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer none

9 BIRTHPLACE (city or town) Ma. (State or country)

10 NAME OF FATHER John Gross

11 BIRTHPLACE OF FATHER (city or town) Ma. (State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Ma. (State or country)

14 Informant Mary Johnson 312 Little Ave

15 Aug 15 1922 ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1922

17 I HEREBY CERTIFY, That I attended deceased from June 26 1922 to Aug 12 1922 that I last saw her alive on Aug 11 1922 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Fortifical Pulmonary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical
(Signed) Chambers M.D.
1317 (Address) 1076 Edmondson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn

DATE OF BURIAL

8.15 1922

20 UNDERTAKER

Robt. L. Parham

ADDRESS

2140

HEALTH DEPARTMENT—CITY OF BALTIMORE

66817

CERTIFICATE OF DEATH.

100-001 D 66817

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 S. Charles ST. 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Houch(a) RESIDENCE. No. 1210 S. Charles ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 9 - 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

155

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Walter W. Houch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Minnie Pfaff

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Minnie Houch
1210 S. Charles St

15

AUG 15 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14th 1922

17

I HEREBY CERTIFY, That I attended deceased from August 13th 1922 to August 14th 1922, that I last saw her alive on August 13th 1922, and that death occurred, on the date stated above, at 4:10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-pneumonia (Acute Congestive Route)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of deathDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Examination(Signed) Harry Heibel M.D.Address 1224 Kanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London ParkAug 15 1922

20 UNDERTAKER

ADDRESS

F. A. Krause & Son700 Hanover

N. B.—WRITE PLAINLY, WITHOUT ADOPTING EMBELLISHMENTS. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No infection prior.

N. B.—WHITE LABEL, WITH ENVELOPE FOR THE STATE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—6-9-19—H. P. Co.—1000 EKS.

D 66818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Blake

(a) RESIDENCE. NO. Unknown

ST. Unknown WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Alice Blake

6 DATE OF BIRTH (month, day, and year)

1877-12-10

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

--8

2--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto
Maryland
Thos. R. Blake

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind
Unknown
Margaret Chase

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind
Unknown

14

Informant

Hospital Records,

(Address)

Municipal Hospital,

AUG 15 1922

Filed

19

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12 1922

17

I HEREBY CERTIFY, That I attended deceased from October 11, 1921, to August 12, 1922, that I last saw him alive on August 11, 1922, and that death occurred, on the date stated above, at 9:00 A.M.. The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

General Paresis

(duration) yrs. 18 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.

Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

8-15-22

20 UNDERTAKER

ADDRESS

Sam'l. H. Chase Wm. H. H. H. H. H.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Luetic

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4202 ST.; 28 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 4202 St.; 28 yrs., 2 mos., 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Single

6-DATE OF BIRTH,

Dec

7

1918

(Month)

(Day)

(Year)

7-AGE,

3 8

yrs. 8 mos. 7 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Balto City

10-NAME OF FATHER,

Howard R. Carr

11-BIRTHPLACE OF FATHER
(State or Country)

Carroll Co. Md

12-MAIDEN NAME OF MOTHER

Mable E. Smith

13-BIRTHPLACE OF MOTHER
(State or Country),

Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Howard R. Carr

(Address)

4202 Gwynn Oak Ave

AUG 15 1922

191

ROBERT N. KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

14

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 14 1922, to Aug 14 1922,

that I saw him alive on Aug 14 1922,

and that death occurred, on the date stated above, at 84. m.

The CAUSE OF DEATH* was as follows:

Acute intestinal intoxication

Cholera

CONTRIBUTORY... Myocardial degeneration

(Signed) J. H. Warner M. D.

Aug 14, 1922 (Address) 2604 Garrison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 4202 Gwynn Oak Ave

Former or usual residence 4202 Gwynn Oak Ave

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

20-UNDERTAKER, ADDRESS

J. S. Marshall 3539 Fell Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66820

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Oxford ST., 17 WARD)

2-FULL NAME

(a) RESIDENCE NO. 510 Oxford ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

AUG 15 1922

ROBERT R. KRAUTER, Registrar

Mical Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1922, to Aug 14, 1922, that I last saw him alive on Aug 13, 1922, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) John H. Thompson M.D.19 (Address) 1017 North Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 140

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66821

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 Charles ST. 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, 1 hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

AUG 15 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from
Aug 14, 1922, to Aug 14, 1922,that I last saw him alive on Aug 14, 1922, 19and that death occurred, on the date stated above, at 7 M. Utero Gestation m.

The CAUSE OF DEATH* was as follows:

Premature Birth
7 M. Utero Gestation
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) R. P. Campbell M. D.
1922 (Address) 1644 Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer8-15 1922

20 UNDERTAKER

ADDRESS

E. O. B. Harle 115 E West St.

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66822

CERTIFICATE OF DEATH.

31

D 66822

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 W. Luzerne ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Shutz(a) RESIDENCE NO. 134 W. Luzerne ST., 6 WARD(Usual place of abode) Length of residence in city or town where death occurred 33 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 12 - 18897 AGE Years 33 Months 7 Days 4 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postman(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)10 NAME OF FATHER Wm. Shutz11 BIRTHPLACE OF FATHER (city or town) Id. (State or country)12 MAIDEN NAME OF MOTHER Margaret Otto13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)14 Informant Margaret Shutz(Address) 134 W. Luzerne St.

AUG 15 1922

Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 19 2217 I HEREBY CERTIFY, That I attended deceased from May 15, 19 22, to Aug 12, 19 22.that I last saw him alive on Aug 12, 19 22.and that death occurred, on the date stated above, at 12:00 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Section(Signed) J. N. Bladed, M. D.(Address) 14370 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cem.

20 UNDERTAKER

Lilly & Zeller

DATE OF BURIAL

Aug 16 19 22

ADDRESS

4038 W. 1st St.

N. B.—WRITE CAREFULLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

66823

HEALTH DEPARTMENT—CITY OF BALTIMORE

66823

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Catapaces ST., 23 WARD)

2-FULL NAME

Florence Hartman

(a) RESIDENCE NO.

1502 Catapaces

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

23 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 OLD OR YOUNG

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

AUG 15 1922

Filed

19

ROBERT A. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb 2 1922, to Aug 12 1922,

that I last saw her alive on Aug 12 1922,

and that death occurred, on the date stated above, at 12, 25th m.

The CAUSE OF DEATH* was as follows:

Acute inflammation of liver
stomach & intestines,

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of Mch 30/22

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) O. H. H. M. D.

, 19 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVING

10 BURIAL

ADDRESS

10 BURIAL

ADDRESS

10 BURIAL

ADDRESS

10 BURIAL

ADDRESS

10 BURIAL

ADDRESS

10 BURIAL

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 S. 13th ST. 76 WARD)2-FULL NAME Anna Dorothy Graham(a) RESIDENCE No. 610 S. 13th

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 2 mos.ST. 76 WARD 76
(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) June 25, 1922

7 AGE

Years 1Months 1Days 20

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)10 NAME OF FATHER Thomas O. Graham11 BIRTHPLACE OF FATHER (city or town) Long Island City N.Y.
(State or country)12 MAIDEN NAME OF MOTHER Dora Jeppkin13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14

Informant Thos O. Graham
(Address) 610 S. 13th St

ROBERT M. KRAUTER,

Bureau Health Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 14, 1922, to Aug 14, 1922.that I last saw her alive on Aug 14, 1922.and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Convulsions (Due to teething)(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Id, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mount Carmel Cem

DATE OF BURIAL

Aug 16 192220 UNDERTAKER John Reelich

ADDRESS

2008 Alameda

N.B.—WRITE PLAINLY, WITH CARE AND PRECISION. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

AUG 15 1922

D 66825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 15 1922

ROBERT N. KRAUTER,

Bureau of Health, Baltimore, Md.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

101

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

157700
D-66826

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66826

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Edward Shelton

(a) RESIDENCE NO.

332 E. Forrest St. City

WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 15 unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a (If married, widowed, or divorced)

HUSBAND of
WIFE ofMaisy Shelton (wife)6 DATE OF BIRTH (month, day, and year) March 8, 18857 AGE 37 Years 5 Months 5 Days LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland10 NAME OF FATHER Sam Shelton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia12 MAIDEN NAME OF MOTHER Matilda

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

PARENTS

14 Informant JOHNS HOPKINS HOSPITAL (Address) Sec 1015 1922Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13, 192217 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1922 to Aug 13, 1922.that I last saw him live on Aug 13, 1922, and that death occurred, on the date stated above, at 11:35 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY Rheumatic Heart Disease (Secondary) Bacterial Endocarditis (duration) yrs. mos. ds.18 Where was disease contracted at home if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) Francis R. Prineas, M. D. Aug 14, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Laural Cemetery

DATE OF BURIAL

Aug 16, 192220 UNDERTAKER Mrs Charles B JonesADDRESS 1725 Ashland

D 66827

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66827

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 913 Hubeland Ave. 16 Ward)

Registered No. C.....

2-FULL NAME

Mr. R. Garner

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 913 Hubeland Ave. 28 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white5-Single, Married, Widowed, or Divorced. (Write the word.) married

6-DATE OF BIRTH,

Feb. 14 1894

(Month)

(Day)

(Year)

7-AGE,

28 yrs. 6 mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. salesman(b) General nature of industry, business, or establishment in which employed (or employer). milk9-BIRTHPLACE, (State or Country), Balto. Md.10-NAME OF FATHER, James Garner11-BIRTHPLACE OF FATHER, (State or Country), Va.12-MAIDEN NAME OF MOTHER, Laura Wags13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. R. Garner(Address) 12 W. Virginia

15-

Filed 1922Robert P. Harrison

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 14 1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, au-topsy or inquiry.) find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

suicide by hanging

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. P. Harrison M. D.(Coroner.) August 14 1922 (Address) 2808 Hubeland Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem.DATE OF BURIAL, Aug. 17 192220-UNDERTAKER, Harry W. EhlenADDRESS 1944 W. North Ave.

D 66828

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66828

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1306 E Monument St., 10 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1306 E Monument St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE Black Single, Married, or Divorced. (Write the word.)

6-DATE OF BIRTH July 4, 1880 (Month) (Day) (Year)

7-AGE 42 yrs. 1 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Charleston Md

10-NAME OF FATHER James Blake

11-BIRTHPLACE OF FATHER, (State or Country) Charleston Md

12-MAIDEN NAME OF MOTHER Rachel Smith

13-BIRTHPLACE OF MOTHER, (State or Country) West Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Blake

(Address) 15 N. Poppel St.

15- Robert P. Harrison, Registrar.

54922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH August 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (Duration) 3 mos. 3 ds.

CONTRIBUTORY (Secondary) (Duration) 0 yrs. 0 mos. 0 ds.

(Signed) J. P. Taylor M. D. (Coroner.) 1922 (Address) 148 E. Monument

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mt Zion Cem Aug 16, 1922

20-UNDERTAKER ADDRESS

Daniel Taylor & Co

Probably lobar pneumonia

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyæmia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicæmia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Snicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

D 66829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1173 Hammer St. 73 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1123 Hammer St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female COLOR OR RACE White

5 Single, Married, Widowed.

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John McQuade

6 DATE OF BIRTH (month, day, and year) Jan 3, 1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66 8 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

John Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ann Farrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14 Informant (Address)

John McQuade 1123 Hammer St.

15 Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1922

17 I HEREBY CERTIFY, That I attended deceased from

1/20/22, 1922, to Aug 12, 1922,

that I last saw him alive on Aug 12, 1922,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Arterio Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. M. McQuade, M. D.

15, 1922 (Address) 1279 Williams St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Ave

Aug 16 1922

20 UNDERTAKER

ADDRESS

Margaret H. Flynn

6422 Light

JG 15 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66830

CERTIFICATE OF DEATH.

D 66830

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hosp.* ST. *100* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Georganna Loudenslager*(a) RESIDENCE NO. *1921 Hollis* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Wm. Loudenslager*6 DATE OF BIRTH (month, day, and year) *1854*7 AGE *68* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*MD*

10 NAME OF FATHER

*William Dorr*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*MD*

12 MAIDEN NAME OF MOTHER

*Unknown*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Maryland*

14

Informant

(Address)

*Wm. J. Loudenslager**1923 W. Lombard*

15

Filed

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 14 1922*

17

I HEREBY CERTIFY, that I attended deceased from *June 12, 1922* to *Aug 14, 1922*.
that I last saw her alive on *August 14, 1922*
and that death occurred, on the date stated above, at *7:50 p. m.*

The CAUSE OF DEATH* was as follows:

*Terminal Bronchopneumonia*CONTRIBUTORY *Senile Dementia*
(Secondary) (duration) yrs. mos. ds. *7*(duration) yrs. mos. ds. *3*18 Where was disease contracted
if not at place of death? *Place of death*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical findings*

(Signed)

, 19 (Address)

Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

London Park

20 UNDERTAKER

J. M. Cook

DATE OF BURIAL

Aug 17 1922

ADDRESS

118 G St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

G 15

1922

Burial Permit Glens

D 66831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66831

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: No. 12 ST. 12 WARD

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 60 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

15 1922

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 1922 to Aug 14, 1922.

that I last saw him alive on April 4, 1922.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 2223 Guilford Ave

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed)

Charles W. M. D.

, 19

(Address)

1327 Oak Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

318 1/2 St. Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66832

CERTIFICATE OF DEATH.

37

D 66832

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2735 Huntingdon Ave. ST. 17 WARD

2-FULL NAME

Bernadine E. Lewis

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE

NO. 2735 Huntingdon Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Dec. 22, 1921

7 AGE Years 0 Months 7 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

William E. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Carrie Shanklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant

(Address)

2735 Huntingdon Ave.

AUG 16 1922

ROBERT A. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1922

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1922, to Aug 15, 1922, that I last saw her alive on Aug 10, 1922, and that death occurred, on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration) yrs. mos. 22 ds.

CONTRIBUTORY

Meningitis - Probable

(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. J. Vonnen M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Perry Hall, Md.

Aug 16 1922

20 UNDERTAKER

ADDRESS

Mr. & Mrs. J. W. Gumpel & Son

801 N. Gay St.

66833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66833

1. PLACE OF DEATH

CITY OF BALTIMORE: No. 101 Virginia Ave. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 101 E. Virginia Ave

(Usual place of abode)

Length of residence in city or town where death occurred

31 yrs.

8 mos.

26 ds.

How long in U. S., if of foreign birth?

37 yrs.

8 mos.

26 ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Nov. 19 1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

31

8

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

Sheet Packers

(c) Name of employer

Swift & Co

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Henry Klingebiel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Lenact Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Henry Klingebiel

15

AUG 16 1922

ROBERT H. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1922, to Aug. 14, 1922,

that I last saw him alive on Aug 13, 1922,

and that death occurred, on the date stated above, at 7:15 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed)

Herbert R. Blake M. D.

Aug 14 1922 (Address)

1014 W. La Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

Western Cemetery Aug 16 1922

ADDRESS

Mrs. John H. Tenzel & Son 801 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66834

CERTIFICATE OF DEATH.

38 D 66834

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Murray(a) RESIDENCE NO. 11 Market Place

(Usual place of abode)

ST., 4 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18727 AGE Years 50 Months -- Days -- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co., Maryland
(State or country)10 NAME OF FATHER John Grover11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Mary Brooks13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Hospital Records,
(Address) Municipal Hospital15 AUG 16 1922 ROBERT R. KRAUTER,
Public Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 19 2217 I HEREBY CERTIFY, That I attended deceased from August 9, 19 22 to August 14, 19 22, that I last saw her alive on August 14, 19 22, and that death occurred, on the date stated above, at 11 P.M. m. The CAUSE OF DEATH* was as follows:Septicemia of Pharynx(duration) 30 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.8/15/22 Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Int. Auburn Aug 17 19 22

20 UNDERTAKER

ADDRESS 142John H. Todman Undertaker

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

128 D 66835

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Gilmer ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 509 N. Gilmer St. St. 28 yrs., 9 mos., 0 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

F

4-COLOR OR RACE,

Col.5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)Single

6-DATE OF BIRTH,

Nov.131893

(Month)

(Day)

(Year)

7-AGE,

289mos.0da.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife9-BIRTHPLACE,
(State or Country),md.

PARENTS.

10-NAME OF FATHER,

Josiah Marine11-BIRTHPLACE OF FATHER
(State or Country),md.

12-MAIDEN NAME OF MOTHER

Janie DeHara13-BIRTHPLACE OF MOTHER
(State or Country),md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Janie Marine(Address) 509 N. Gilmer St.

15-

Filed

AUG 15 1922

ROBERT R. KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 13, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 1 1922, to Aug. 13 1922,that I saw him alive on Aug. 13 1922,and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Acute interstitial nephritis(Duration) 23 yrs.CONTRIBUTORY
(Secondary)(Duration) 23 yrs.(Signed) James M. Hays M. D.8/14, 1922 (Address) 1046 Beech St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 28 yrs., 9 mos., 0 da. In the State 28 yrs., 9 mos., 0 da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Int. AuburnAug. 16, 1922

20-UNDERTAKER

ADDRESS 142John H. FoadinW. Hill St.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66836

CERTIFICATE OF DEATH.

44 D 66836

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #42-Roland Court

ST.: 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MOLLIE LOUISE HOPKINS.

(a) RESIDENCE. No. #42-Roland Court. ST.: 27 WARD. (Resident)

(Usual place of abode)
Length of residence in city or town where death occurred 60 yrs. 8 mos. 23 ds. How long in U. S., if of foreign birth? 60 yrs. 8 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (None)

6 DATE OF BIRTH (month, day, and year) November-22-1851

7 AGE Years 60 Months 8 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER William L. Hopkins

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER AnnElizaReese

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland14 Informant Miss Bessie Hopkins (sister)
(Address) 42-Roland Court, City.

15 AUG 16 1922 ROBERT N. KRAUTER.

Rudal Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1922

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1922, to Aug 14, 1922, that I last saw him alive on Aug 13, 1922, and that death occurred, on the date stated above, at 12:45 a.m.

The CAUSE OF DEATH* was as follows:

Gangrenoma of stomach and liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 4/4 Date of July 11

Was there an autopsy? No

What test confirmed diagnosis? Exposure of part
(Signed) John A. Giddis, M. D.
, 19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. OLIVET CEMETERY

Aug-16-22

20 UNDERTAKER

STEWART & MOWEN COMPANY
WILLIAM F. STEWART, President

ADDRESS

101 N. Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. E. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66837

CERTIFICATE OF DEATH.

REGISTERED NO. 66837

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

October 21, 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stock Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Martinsburg, West Virginia

10 NAME OF FATHER

William Clabaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country)

U. S. A.

12 MAIDEN NAME OF MOTHER

Lucelia Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

U. S. A.

14

Informant (Address)

Carroll G. Spinks, 1300 N. Mass

15

AUG 16 1922

ROBERT R. MAUTER

Registrar

Barth Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15th, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 10th, 1922, to Aug. 15th, 1922,

that I last saw him alive on Aug. 14th, 11 P.M., 1922,

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

General Apoplexy with right Hemiplegia, duration 5 ds.

CONTRIBUTORY Stomach Artery Aneurysm, (Secondary) duration 10+ yrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) William Brinton, M.D.

, 19 (Address) 1400 N. Calvert Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount Cem

DATE OF BURIAL

8-16 1922

20 UNDERTAKER

Henry W. Jenkins & Sons Co. Orchard

ADDRESS

McLellan

D 66838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66838

1-PLACE OF DEATH

Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna Lewis Silberman

(a) RESIDENCE. No. 621 W. Redwood city ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

13 yrs

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Hebrew White

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Lewis Silberman

6 DATE OF BIRTH (month, day, and year) Mar 30 1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

40

4

15

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

10 NAME OF FATHER Isaac Shapiro

11 BIRTHPLACE OF FATHER (city or town) Russia

(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) Russia

(State or country)

14

Informant (Address)

S. Silberman 621 W. Redwood St.

15

File

AUG 16 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 19, 1922, to August 15, 1922,

that I last saw her alive on Aug 15, 1922,

and that death occurred, on the date stated above, at 10:08 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Purpura
Heart failure

(duration) yrs. mos. 17 ds.

CONTRIBUTORY Pneumonia

(Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward M. Howard, Jr., M. D.

8/15/22 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Redale

Aug 16 1922

20 UNDERTAKER

ADDRESS 1127

Holmes & Co. Baltimore

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Auricular fibrillation.
Hypostatic pneumonia.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

66840

CERTIFICATE OF DEATH.

X 31 D 66840

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Greenspring Ave. Baltimore* *27* WARD)2-FULL NAME *Ruth J. Lanier*(a) RESIDENCE. NO. *Greenspring Ave. Washington ST.* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. *1* mos. *5* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female**white**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 12 1892*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*49**8**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Costs Bureau 086

(b) General nature of industry, business, or establishment in which employed (or employer)

Washington D.C.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Oxford N.C.

10 NAME OF FATHER

Marcellus B. Lanier

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Lucretia R. Hicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

14

Informant (Address)

Mary Lanier Greenspring Ave

15

*Aug 16 1922**ROBERT R. KRAUTER*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 14 1922*

17

I HEREBY CERTIFY, That I attended deceased from *July 27*, 1922, to *Aug 14*, 1922, that I last saw her alive on *Aug 13*, 1922, and that death occurred, on the date stated above, at *3:45 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration) *one* yrs. *—* mos. *—* ds.(duration) *2* yrs. *—* mos. *—* ds.

18 Where was disease contracted If not at place of death?

Not Known

Did an operation precede death?

yes (date of *Sept 10 1922*)

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

Charles G. Hill, M. D.

19 (Address)

Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park Cemetery**Aug 16 1922*

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North Ave

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Howard A. Kelly Hospital: 10th*)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode) *Massontown, Fayette St. Penn.*Length of residence in city or town where death occurred *1* yrs. *10* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 4 1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*67**4**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Coal Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Massontown Fayette Co. Penna

10 NAME OF FATHER

Dr. George W. Neff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Penna

12 MAIDEN NAME OF MOTHER

Mary Ann Rhoads

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Covington Kentucky

14 Informant

(Address)

Dr. George W. Neff Jr. Massontown Penna

AUG 16 1922

ROBERT A. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 15 1922*

17

HEREBY CERTIFY, That I attended deceased from

*Oct. 9, 1920, to Aug. 15, 1922*that I last saw him alive on *Aug. 15, 1922*and that death occurred, on the date stated above, at *6:50 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Ear(duration) *4* yrs. mos. ds.

CONTRIBUTORY

(Secondary) *L* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Guy N. Cromwell* M. D.Aug 15 1922 (Address) *1418 Eutam Place*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Uniontown Penna

DATE OF BURIAL

Aug 16 1922

20 UNDERTAKER

*Chas. G. Black 742 W. North**ave*

N. B.—WRITE PLAINLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

66842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66842

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Salzman(a) RESIDENCE NO. Grander Lane
(Usual place of abode)ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 19057 AGE Years Months Days If LESS than 1 day, hrs. or min.
17 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland10 NAME OF FATHER Abraham Salzman11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia12 MAIDEN NAME OF MOTHER Sarah Nitash13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia14 Informant Hospital Records,
(Address) Municipal Hospital.15 AUG 16 1922 ROBERT R. KAUTER,
Bureau Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 19 2217 I HEREBY CERTIFY, That I attended deceased from
July 28, 19 22, to August 14, 19 22.that I last saw him alive on August 14, 19 22.and that death occurred, on the date stated above, at 11:25 P.M.

The CAUSE OF DEATH* was as follows:

Epidemic meningitis(duration) yrs. mos. 2 / ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis?
(Signed) Clyde McNeil, M. D.8/15/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Wehren Rosedale 8/16 19 22

20 UNDERTAKER

ADDRESS

Jack Lewis 1439

N. B.—WRITE FULL NAME OF DECEASED IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Poultney

ST. 23 WARD)

2-FULL NAME

Frances Levina Assmann

(a) RESIDENCE NO.

30 Poultney

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frank Assmann

6 DATE OF BIRTH (month, day, and year) April 12 1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

4

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md.

10 NAME OF FATHER Wm. W. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not known

12 MAIDEN NAME OF MOTHER Mary C. Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant (Address)

Frank Assmann

30 Poultney St.

15

AUG 16 1922

ROBERT R. KRAUTER,

Burial Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Mrs. 11-1921, to August 15, 1922, that I last saw her alive on August 14, 1922, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration)

yrs. 9

mos.

ds.

(duration)

yrs.

mos. 6

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? or Date of

Was there an autopsy? or

What test confirmed diagnosis?

(Signed)

8/15, 1922 (Address)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cedar Hill Cemetery

Aug 18 1922

20 UNDERTAKER

ADDRESS

John F. Denny

715 Light St

N. B.—WRITE FULL NAME OF PHYSICIAN, Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66844

CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. 1026 Mc Culloch St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Hattie Tillman
(Residence in Baltimore: No. 1026 Mc Culloch St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX fh. 4-COLOR OR RACE, C. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married
6-DATE OF BIRTH Unknown, 1 (Month) (Day) (Year)
7-AGE, 22 yrs. mos. ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work Housework (b) General nature of industry, business, or establishment in which employed (or employer) 037
9-BIRTHPLACE (State or Country) Peru, Indiana
10-NAME OF FATHER Unknown
11-BIRTHPLACE OF FATHER (State or Country) "
12-MAIDEN NAME OF MOTHER "
13-BIRTHPLACE OF MOTHER (State or Country) "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Tillman

(Address) 1026 Mc Culloch St.

AUG 16 1922

Filed 191 REGISTRAR.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 13, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, and that said deceased came to death

on the day stated above. The CAUSE OF DEATH was as follows: Gunshot wound of neck
Accidental

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John H. Morrissey M. D. (Address) 3632 Roland St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Auburn Cemetery DATE OF BURIAL, August 16 1922

20-UNDERTAKER, JOHN A BISHOP & SON ADDRESS, 1107 Druid Hill Avenue

D. 66845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66845

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1446 Richardson St. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

Jennie Grabowski.

30 -----

(Residence in Baltimore: No. 1446 Richardson St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, August 29, 1891. 1. (Month) (Day) (Year)

7-AGE, 30 yrs. 11 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Poland.

10-NAME OF FATHER, Simon Novak.

11-BIRTHPLACE OF FATHER, (State or Country), Poland.

12-MAIDEN NAME OF MOTHER, Antonina Promiensi

13-BIRTHPLACE OF MOTHER, (State or Country), Poland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Frank Novak, (brother).

(Address), 1446 Richardson St.

AUG 16 1922

ROBERT A. KRAUTER,

1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 14th, 1922. 192. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry. And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

Aug. 15, 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Stanislaus Aug 17, 1922

20-UNDERTAKER, ADDRESS

John B. Weber 1803 Park St.

D 66846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1043 Mount ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Benjamin Milligan, Jr.

(a) RESIDENCE NO. 1043 Mount ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Aug 14, 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER James Benjamin Milligan

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Ruth Leone Russell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Mother, 1043 Mount St (Address)

AUG 16 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 14, 1922 to Aug 15, 1922 that I last saw him alive on Aug 14, 1922 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY Premature birth (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann of mother

(Signed) Susanna R. Parsons, M. D.

, 19 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Zion Cemetery

20 UNDERTAKER

Mrs. M. Johnson

DATE OF BURIAL

Aug. 16, 1922

ADDRESS 1238

Ething St.

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 66847

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Wallis Ave. Belington St.* WARD)

2-FULL NAME

(a) RESIDENCE. No. *Wallis Ave. Belington St.* WARD.Length of residence in city or town where death occurred *8* yrs. *—* mos. *—* ds. How long in U. S., if of foreign birth? *—* yrs. *—* mos. *—* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Single*6 DATE OF BIRTH (month, day, and year) *April 6, 1870*

7 AGE

Years

Months

Days

If LESS than
1 day, *—* hrs.
or *—* min.*52**4**14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Real Estate, 86

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Employer
Baltimore*9 BIRTHPLACE (city or town)
(State or country)*Maryland*

10 NAME OF FATHER

Thomas J. Welley

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Frances J. Bevelton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pennsylvania

14

Informant
(Address)*Mrs. Frances Welley
Wallis Ave.*

15

AUG 16 1922

ROBERT N. WEAVER

Deputy Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 16* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

July 15, 19 *22*, to *Aug 16*, 19 *22*,that I last saw him alive on *Aug 25*, 19 *22*,and that death occurred, on the date stated above, at *home* *10:30* p.m.

The CAUSE OF DEATH* was as follows:

*On Aug 15 patient in apical heart
+ Cheyne-Stokes & was found dead
when called for transport this morning
Heart lesion (duration) *—* yrs. *—* mos. *—* ds.*CONTRIBUTORY I have been training for
(Secondary) *for 2 yrs for Pennsylvania* (duration) *—* yrs. *—* mos. *—* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Chemical test*(Signed) *Charles B. Hill*, M. D., 19 (Address) *Wylie Ave. Annapolis*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery *Aug 19* 19 *22*

20 UNDERTAKER

ADDRESS

John B. Spencer, 1325 N. Towline St.

Information should be carefully supplied. Exact statement of OCCASION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Valvular Heart Disease

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66848

CERTIFICATE OF DEATH.

D 66848

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *1138 Bridgley*)ST. *21* WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1138 Bridgley St.*)St. *1* yrs. *1* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

single

6-DATE OF BIRTH,

July 3rd, 1921
(Month) (Day) (Year)

7-AGE,

*1 yrs. 1 mos. 12 ds.*If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*none*

9-BIRTHPLACE, (State or Country),

Baltimore Md.

10-NAME OF FATHER,

George Windisch

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Anton

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. E. Windisch

(Address)

1138 R. Bridgley St.

15

AUG 16 1922

ROBERT N. KNAUTER,

Baltimore Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 15, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 9th 1922, to Aug 15th 1922*that I saw him alive on *Aug 14th 1922*and that death occurred, on the date stated above, at *7:00 A.M.*

The CAUSE OF DEATH* was as follows:

Exhaustion

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Gastro-enteritis

(Duration).....yrs.....mos.....ds.

(Signed)

J. E. Poulton M. D.*815 1/2 St. 191* (Address) *654 Columbia Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*Beder Hill Cemetery**Aug 16, 1922*

20-UNDERTAKER

ADDRESS

*Geo Leimbach & Son**647 W. Pratt St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1843 Hanover ST., 23 WARD)

2-FULL NAME

Caroline Irene Conway

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1843 Hanover

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 5 mos.ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Isaac Henry Conway6 DATE OF BIRTH (month, day, and year) March 23 18627 AGE (60) Years 5 Months — Days If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Henry Metzger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Metzger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Isaac Henry Conway
1843 Hanover St.

15

Robert P. Harrison,Barial Permit Clerk,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16, 192217 I HEREBY CERTIFY, That I attended deceased from July 15, 1922 to Aug 16, 1922that I last saw her alive on Aug 15, 1922and that death occurred, on the date stated above, at 8:40 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. O'Connor, M. D.(Address) 4704 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

DATE OF BURIAL

8-18-1922

20 UNDERTAKER

E. B. Harle 115 E West St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 161922

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Not ileo colitis
Not very strong
Infy. Congenital
debility

D 66850

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1409 Battery Ave. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

George Kern.

38 -- 11 -- 8.

(Residence in Baltimore: No. 1409 Battery Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH, September 6, 1883. (Month) (Day) (Year)

7-AGE, 38 yrs. 11 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Steam (b) General nature of industry, business, or establishment in which employed (or employer), pipe fitter.

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Conrad Kern.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth

13-BIRTHPLACE OF MOTHER, (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Manie Kern. (wife).

(Address), 1409 Battery Ave.

15-

Robert P. Harrison,

107

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 14th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. W. Richardson M. D. (Coroner)

Aug. 15, 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral Cemetery, 8/17/1922

20-EMERALD, ADDRESS

E. D. Higgins, 1460 Battery

REG.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

16 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66852

CERTIFICATE OF DEATH.

123 D 66852

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 W. Franklin

ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Snyder

(a) RESIDENCE. NO.

1906 W. Franklin

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos.

ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widowed

5a If married, widowed, or divorced

(or) wife of

Katie B. Snyder

6 DATE OF BIRTH (month, day, and year)

Sept 23, 1842

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

11

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cigar-maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Godfrey Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna M. Wiegol

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Sarah Snyder, 243 N. Monroe St.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 16, 1922, to August 16, 1922;

that I last saw him alive on August 15, 1922,

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Suppurative cholecystitis

CONTRIBUTORY (Secondary)

(duration) — yrs. 2 mos. — ds.

Cholelithiasis

(duration) 8 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? palpation + clinical signs

(Signed) Egbert L. Mortimer, M. D.

8-16-1922 Address) 530 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Soudon Park

DATE OF BURIAL

AUG 18 1922

20 UNDERTAKER

Geo W Little

ADDRESS 2700

EDMONDSON AVE.

Exact statement of OCCUPATION should be carefully reported. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

G 161922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66853

D 66853

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 N - Carey ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Loris Harris

(a) RESIDENCE NO.

1519 N - Carey

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3mos. 12

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 3-12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engan

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER Paul J. Harris11 BIRTHPLACE OF FATHER (city or town) (State or country) City12 MAIDEN NAME OF MOTHER Petera Caulk13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14

Informant (Address) Robert P. Harrison

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-1922

17

I HEREBY CERTIFY, That I attended deceased from

8-7-, 1922, to 8-16-, 1922,that I last saw him alive on 8-14-, 1922,and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Intestinal indigestion(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Gargill

M. D.

8-16, 1922 (Address) 611 N - Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Exact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

16 1922

Burial Permit Clerk

D 66854 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 174 D 66854

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *11* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Truman Skinner*(a) RESIDENCE. NO. *608 N. Calvert St.* ST. WARD.(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Dec 31, 1870*6 DATE OF BIRTH (month, day, and year) *Aug 15-1922*7 AGE Years *51* Months *8* Days *809* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Clock*(b) General nature of industry, business, or establishment in which employed (or employer) *Industrial*(c) Name of employer *Crown Cord & Seal*9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)10 NAME OF FATHER *Truman Skinner*11 BIRTHPLACE OF FATHER (city or town) *London Co.* (State or country) *Virginia*12 MAIDEN NAME OF MOTHER *Isabell Countable*13 BIRTHPLACE OF MOTHER (city or town) *Chesapeake* (State or country) *Maryland*14 Informant *Brother - Wm C. Skinner* (Address) *1019 Linden Ave*15 *Robert P. Harrison,* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 15* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 14* 19 *22* to *Aug 15* 19 *22*that I last saw him alive on *Aug 15* 19 *22*and that death occurred, on the date stated above, at *6* A.M.

The CAUSE OF DEATH* was as follows:

*Maemia*CONTRIBUTORY *Chronic diffuse nephritis* (duration) yrs. mos. *3* ds. (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical signs*(Signed) *W. S. Jones* M. D.19 *1922* Address *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*London Park**Aug 17* 19 *22*

20 UNDERTAKER

*Harry H. Witzke**1531 W. Lombard*Exact statement of OCCUR-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66855

66855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 12 WARD)

2-FULL NAME

Anna Thomas

(a) RESIDENCE. No.

200 East 31st

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

widow

5a If married, widowed, or divorced

(or) WIFE of

Thomas

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

don't know

12 MAIDEN NAME OF MOTHER

don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

don't know

14

Informant (Address)

Hospital Records

15

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/15 1922

17

I HEREBY CERTIFY, That I attended deceased from

7/18/22, 19, to 8/15/22, 19

that I last saw her alive on 8/15/22, 19

and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma uterus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed)

J. A. McKoy, M.D.

, 19

(Address)

Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cemetery

Aug 17 22

20 UNDERTAKER

ADDRESS

Harry H. Witzke

15316 Lombard

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

6 16 1922

Burial Permit Clerk:

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 31 N. Caroline ST.: 6 WARD)REGISTERED NO. 4001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jenkins(a) RESIDENCE. NO. 31 N. Caroline T. 6 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 50 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE Col5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years 62

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14

Informant
(Address) Officia Fisher
31 N. Caroline

15

AUG 17 1922

ROBERT R. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct - 5, 1922 to Aug 16, 1922
that I last saw him alive on Aug 13, 1922.and that death occurred, on the date stated above, at 1/01 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Bums

M. D.

, 19

(Address) 228 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL LaurelDATE OF BURIAL Aug 18 192220 UNDERTAKER John W. HendersonADDRESS 1501E. Mount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Apoplectic.

Information should be carefully supplied. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 74-001 D 66857
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, NO. 538 Potomac Ave. ST. 25 WARD

2-FULL NAME

Jennie A. E. Myers

(a) RESIDENCE NO.

538 Potomac Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Wm. George Myers

6 DATE OF BIRTH (month, day, and year)

Nov 6, 1852

7 AGE

69

Months

7

Days

8

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Has done nothing for several years.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Towneytown Ind.

10 NAME OF FATHER

Israel Dem

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Carroll Co. Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Crise

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Carroll Co. Md.

14

Informant (Address)

Florence R. Dietrich 538 Potomac Ave.

15

Aug 17 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 14 1922

17

I HEREBY CERTIFY, That I attended deceased from July 1st, 1922, to Aug. 14, 1922, that I last saw her alive on Aug. 14, 1922, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Geo. B. Davis, M. D.

8/15, 1922 (Address) 211 Church St., Center City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Boneta Church Yard

20 UNDERTAKER

John F. Demmy

DATE OF BURIAL

Aug 17 1922

ADDRESS

715 Light St

D 66858

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C. 66858

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 N. Dallas St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Weldon

(Residence in Baltimore: No. 1113 N. Dallas St., yrs. 14 mos. 14 ds.)

Phila. Pa. 2310 N. Albemarle St.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE, Black 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Dec 1882 (Month) (Day) (Year)

7-AGE, 39 yrs. 8 mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housemaid (b) General nature of industry, business, or establishment in which employed (or employer), 070

9-BIRTHPLACE, (State or Country), St. Mary's Co. Md.

10-NAME OF FATHER, Thomas Weldon

11-BIRTHPLACE OF FATHER, (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Charlotte Taylor

13-BIRTHPLACE OF MOTHER, (State or Country), St. Mary's Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lurmin Peaker

(Address) 1113 N. Dallas St.

15-

Filed

AUG 17 1922

ROBERT M. KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic Heart, Valvular Insufficiency

(History - probably syphilitic)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ezema

(Duration) yrs. mos. ds.

(Signed) J. S. H. Patton, M. D.

(Address) 508 E. North Ave.

1922 (Address) 508 E. North Ave.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mount Auburn Aug 17 1922

20-UNDERTAKER, ADDRESS

John H. Owens 538 W. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE, 001

D 66859

CERTIFICATE OF DEATH.

D 66859

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant Infirmary* ST.: *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Theron Hall Rice*(a) RESIDENCE. NO. *Richmond, Va.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *7* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 8th 1867*7 AGE Years *55* Months *1* Days *9* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Minister*(b) General nature of industry, business, or establishment in which employed (or employer) *018*

(c) Name of employer

9 BIRTHPLACE (city or town) *Alabama* (State or country)10 NAME OF FATHER *Theron H. Rice*11 BIRTHPLACE OF FATHER (city or town) *Tenn.* (State or country)12 MAIDEN NAME OF MOTHER *Lydia B. Root*13 BIRTHPLACE OF MOTHER (city or town) *Kentucky* (State or country)14 Informant *Mr. T. H. Rice* (Address) *Richmond Va*15 *AUG 11 1922*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 17* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

June 27, 19 *22*, to *Aug 17*, 19 *22*.that I last saw him alive on *Aug 17*, 19 *22*.and that death occurred, on the date stated above, at *4:35 a.m.*

The CAUSE OF DEATH* was as follows:

Intestinal adhesions following operation for gastric ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY *Broncho pneumonia* (Secondary)(duration) yrs. mos. *4* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *June 27* *July 12*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*(Signed) *P. B. Price*, M. D., 19 (Address) *Union Memorial Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Richmond Va**Aug 17* 19 *22*

20 UNDERTAKER

Henry Jenkins, Inc ADDRESS *Belair Ave Baltimore*

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 E. Cross St.

ST.: 24 WARD)

2-FULL NAME

Walbergia O Keefe

(a) RESIDENCE. NO.

207 E. Cross St.

ST.: WARD.

(If nonresident give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-16-22

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Ernest Richard O Keefe

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Wallia Geisenkot

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14

Informant
(Address)Ernest R. O'Keefe
207 E Cross St Baltimore

15

Filed

19

AUG 17 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-22

17

I HEREBY CERTIFY, That I attended deceased from

8-16, 1922, to 8-16, 1922

that I last saw her alive on 8-16, 1922

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis of
lungs? (never breathed
properly) (8 months
gestation)CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

James Brown, M. D.

8/17/1922 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross A A B

8-17 1922

20 UNDERTAKER

ADDRESS

E B Hark 115 E West St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66861 HEALTH DEPARTMENT—CITY OF BALTIMORE 1120 66861

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 N. Hoffman ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Danish

(a) RESIDENCE NO. 531 N. Hoffman ST. WARD

(Usual place of abode) Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE 78 Years 1844 June 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Elizabeth M. Smith

15 AUG 17 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1922, to Aug. 14, 1922, that I last saw him alive on Aug. 14, 1922, and that death occurred, on the date stated above, at 8:40 P. M. The CAUSE OF DEATH* was as follows:

acute Isentitis

CONTRIBUTORY (Secondary) General Debility (duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins, M. D.

(Address) 1019 Duval Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL Aug 17, 1922

2 UNDERTAKER Samuel Danushy

ADDRESS 578

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 66862

CERTIFICATE OF DEATH

D 66862

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1341 Cooks St. ST. 24 WARD)

2-FULL NAME Franz. Westmann

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1341 Cooks St. St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED married (Write the word)

6-DATE OF BIRTH Sept. 13, 1872 (Month) (Day) (Year)

7-AGE 49 yrs. 11 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Brass Fitter (b) General nature of industry, business, or establishment in which employed (or employer) Balto Tube Works

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER Franz Westmann

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Betty Kerchhoff

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Westmann

(Address) 1341 Cooks St.

15-AUG 17 1922 Filed 191

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH August 15, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from August 4, 1922 to August 15, 1922 that I saw him alive on Aug. 14, 1922 and that death occurred, on the date stated above, at 7:45 a.m. The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Decompensation
(Duration) yrs. mos. ds. 12 ds.

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Thos. H. Stevens M. D. Aug 15, 1922 (Address) 2878 Hager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

London Park Aug 18, 1922

20-UNDERTAKER ADDRESS

William Cook 502 E North

D 66863

HEALTH DEPARTMENT—CITY OF BALTIMORE

B1 D 66863

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Cliffview Ave.

ST.:

WARD) 8

Charles A. Wise.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1609 Cliffview Ave.

ST.:

WARD.

(Usual place of abode)

12

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofAnnie
E. Wise.

6 DATE OF BIRTH (month, day, and year) March 21, 1891

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

31

4

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Trunkmaker

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Virginia

10 NAME OF FATHER Edward A. Wise.

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER Barbara E. Prince.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Virginia.

14

Informant
(Address)Mrs. Mary E. ~~Wise~~ *Monroe*
1609 Cliffview Ave.

15

FILE

AUG 17 1922

ROBERT R. KRAUTER

20 UNDERTAKER

William Cook, 502 E. North Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 16 1922

17 I HEREBY CERTIFY, that I attended deceased from

Jan. 1, 1920 to Aug. 16, 1922

that I last saw him live on Aug. 14, 1922

and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary
tuberculosis
(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. *Brumfield* M. D.

, 19 Address 1531 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR REMOVAL
Loudon Park.DATE OF BURIAL
8/18/22

19

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

31 E. North Ave. Burial Permit Clerk

D 66864 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: No. *Pratt Green St.* St. *14* Ward

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1805 Bonnet St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Col.* 5-Single, Married, Widowed, or Divorced. *Married*
(Write the word)6-DATE OF BIRTH, *Don't Know*
(Month) (Day) (Year)7-AGE, *5-5- about* If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Labmr.*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Don't Know*PARENTS.
10-NAME OF FATHER, *1*
11-BIRTHPLACE OF FATHER, (State or Country), *1*
12-MAIDEN NAME OF MOTHER, *1*
13-BIRTHPLACE OF MOTHER, (State or Country), *1*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

AUG 17 1922

J. E. Mehm Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 14*, 19*22*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* and that said deceased came to *his* death *on the day stated above.* (Cause of death.)
The CAUSE OF DEATH* was as follows:*Valvular Heart disease*

CONTRIBUTORY (Secondary)

(Signed) *J. E. Mehm* M. D. (Coroner.)
8-16 19*22* (Address) *112 W. Saratoga St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

1 Mt. Auburn *Aug 18*, 19*22*20-UNDERTAKER, ADDRESS *1305**James H. Mehm* *Christman*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66865

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 66865

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2305 Orem Avenue

ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Fannie Sarah Craig

(a) RESIDENCE NO.

2305 Orem Avenue

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. -- mos. -- ds.

How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

J. Morrell Craig

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1842

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

79

8

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER John E. Davis

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Sarah Thompson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

Mrs. Frances S. Mitchell

(Address)

2305 Orem Avenue

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from
Aug 1, 1922, to Aug 16, 1922.

that I last saw her alive on Aug 15, 1922.

and that death occurred, on the date stated above, at Aug 16 8 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic.

(duration)

1 yrs. -- mos. -- ds.

CONTRIBUTORY
(Secondary)Probable embolus
sudden

(duration)

yrs. -- mos. -- ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

K. J. G. M. D.

, 19 (Address)

2731 Parkview

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Mount Cemetery

DATE OF BURIAL

8/18, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66866

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-002
D 66866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp. 25* St. *25* Ward)

2-FULL NAME

Benedict Brzuchalski
(Residence in Baltimore: No. *105 3rd Ave. Wagners Pl.* St.; yrs. mos. ds.)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.)6-DATE OF BIRTH, *Dec 18*, 192*2*
(Month) (Day) (Year)7-AGE, *7* yrs. *29* mos. *29* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Wagners Pl. Md.*PARENTS.
10-NAME OF FATHER, *John Brzuchalski*
11-BIRTHPLACE OF FATHER, (State or Country), *Balt. Md.*
12-MAIDEN NAME OF MOTHER, *Helen Haluch*
13-BIRTHPLACE OF MOTHER, (State or Country), *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Brzuchalski*
(Address) *124 Third and*

15-

Robert P. Harrison,

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 16*, 192*2*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held no *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* and that said deceased came to *death* (Inquest, autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:*Dysentery*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. S. Patton* M. D.
(Coroner.)
Aug 17 192*2* (Address) *568 E. N. Ave.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Trau-
sients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

John Brzuchalski *Aug 18*, 192*2*

20-EMERGENCY, ADDRESS

John Brzuchalski *803 Bank*

State CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

17 1922

Bacillary dysentery. Died abt 2 hrs after entrance to Hopkins Hosp. History from

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., or (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyemia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicemia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

D 66867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 E. Pleasant ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lina Thomas(a) RESIDENCE. NO. 6 E. Pleasant ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Thomas6 DATE OF BIRTH (month, day, and year) July 4 18537 AGE Years 69 Months 1 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bermy10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Bermy12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermy14 Informant Louisa Thomas (Address) 6 E. Pleasant St.15 Robert P. 1861, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 192217 I HEREBY CERTIFY, That I attended deceased from January, 1922, to Aug 17, 1922, that I last saw him alive on Aug 15, 1922, and that death occurred, on the date stated above, at 4 30 p. m.

The CAUSE OF DEATH* was as follows:

Calcular Heart disease

CONTRIBUTORY (Secondary)

(duration) 3 yrs. mos. ds.Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. C. Deegen, M. D.19 (Address) 1702 E. Pleasant Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Green Hill Cem Aug 19 1922

20 UNDERTAKER

E. SchlomanADDRESS 1034Green Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

17 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66868

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

Pronounced dead
1729 W Lombard

St.

Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anna Morgan

(Residence in Baltimore: No.

1721 W Lombard

St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female
4-COLOR OR RACE, white
5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH,

June 26, 1917
(Month) (Day) (Year)

7-AGE,

6 yrs., 10 mos., 20 ds.

If LESS than 1 day,

.....hrs. or.....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

Balt City

10-NAME OF FATHER,

Evans Morgan

11-BIRTHPLACE OF FATHER,

(State or Country), Baltimore

12-MAIDEN NAME OF MOTHER,

Edith Harris

13-BIRTHPLACE OF MOTHER,

(State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edith Morgan

(Address)

1721 W Lombard

15 AUG 18 1922

Filed

ROBERT N. KRAUTER,

Bureau Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 16, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Chest
and movable accident
sudden
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) James M. [unclear] M. D.
(Coroner.)

Aug 7, 1922 (Address) 750 E Charles

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Garden Park Aug 18, 1922

20-UNDERTAKER,

ADDRESS

John F. Tiller 1200 W Lombard

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Large statement on back of certificate. is very important. See instructions on back of certificate.

D 66869 HEALTH DEPARTMENT—CITY OF BALTIMORE 66869

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2013 Ething ST. 14 WARD 90

2-FULL NAME Elizabeth E. Bentley

(a) RESIDENCE. No. 2013 Ething ST. WARD.

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15, 1862

7 AGE Years 60 Months 2 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis (State or country) Md.

10 NAME OF FATHER Nathaniel Brown

11 BIRTHPLACE OF FATHER (city or town) Mt Vernon (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Ella Ray

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant Mr. Bentley (Address) 2013 Ething

15 AUG 18 1922 ROBERT H. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1922

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1922, to Aug 16, 1922, that I last saw her alive on Aug 16, 1922, and that death occurred, on the date stated above, at 9:50 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Left Hemisphere)

CONTRIBUTORY (duration) yrs. mos. ds. Chr. Valvular Heart Disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted? If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History of case

(Signed) James J. Jones, M. D.

8/16 1922 Address 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Zion Lm

20 UNDERTAKER

Daniel Easton

DATE OF BURIAL

Aug 18 1922

ADDRESS

916 Penna Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

66870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 66870

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 Richmond ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 223 Richmond St.; 6 yrs., 1 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH

(Month) 12 (Day) 31 (Year) 1887

7-AGE

31 yrs., mos., ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Domestic
037

9-BIRTHPLACE, (State or Country),

MD

PARENTS.

10-NAME OF FATHER

John Henry

11-BIRTHPLACE OF FATHER (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Mary Elizabeth

13-BIRTHPLACE OF MOTHER (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Easton

(Address) 516 Beacon

15-AUG 18 1922

ROBERT R. KRAUTER

Filed..... 191..... Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 15th, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 3rd 1912, to 15th 1912,

that I saw her alive on Aug 11th 1912,

and that death occurred, on the date stated above, at 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) None known yrs. mos. ds.

(Signed) Chas. J. Keller M. D.

Aug 15, 1912 (Address) 222 W. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

MD

DATE OF BURIAL,

Aug 18, 1912

20-UNDERTAKER

David Easton

ADDRESS

516 Beacon

important. See instructions on back of certificate.

THIS CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D 66871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3908 Belle Ave St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3908 Belle Ave St. 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH, Nov. 27 1889 (Month) (Day) (Year)

7-AGE, 32 yrs. 8 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work. Wm. J. Ford
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), MD.

10-NAME OF FATHER, ? Kemp

11-BIRTHPLACE OF FATHER, (State or Country), MD.

12-MAIDEN NAME OF MOTHER, W. K.

13-BIRTHPLACE OF MOTHER, (State or Country), MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. F. Mass

(Address) 3908 Belle Ave

15 AUG 18 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) 3 yrs. mos. ds.

(Signed) J. J. Heenan M. D. (Coroner.)

(Address) 2802 E. Baltimore

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

David Ridge Lea 8/18, 1922

20-UNDERTAKER, ADDRESS

H. J. Tschmes & Son 1000 N. Ave.

CERTIFICATE OF DEATH.

REGISTERED NO

66872

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2425 ST. 141 WARD 33
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 0 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/15 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10th, 1922, to Aug 15th, 1922, that I last saw him alive on Aug 15th, 1922, and that death occurred, on the date stated above, at 6:10 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

CONTRIBUTORY
(Secondary)

... (duration) ... yrs. 2 mos. ... ds

(duration) yrs. mos. ds

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Pap smear

(Signed) D. C. Brumby M.D.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL
---	----------------

20 UNDERTAKER ADDRESS

Burial Permit Register

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D 66873

HEALTH DEPARTMENT—CITY OF BALTIMORE

66873

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hospital* 7 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Pulaski Va* St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH

April 15 1903
(Month) (Day) (Year)

7-AGE

19 yrs. 4 mos. 2 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *R.R. Brakeman*
(b) General nature of industry, business, or establishment in which employed (or employer) *073*

9-BIRTHPLACE, (State or Country),

Va.

10-NAME OF FATHER,

R.D. Richardson

11-BIRTHPLACE OF FATHER, (State or Country),

Va

12-MAIDEN NAME OF MOTHER,

Lucy Hartwick

13-BIRTHPLACE OF MOTHER, (State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Johns Hopkins Hosp.

(Address)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 17 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest, autopsy or inquiry* find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Portable fracture of base of skull. Subsequent cerebral hemorrhage. (over)

(Duration) yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

Probably accidental body found near R.R. at Pulaski, Va.

(Signed) *J.S. Hatten* M.D. (Coroner.)

8-17 1922 (Address) *508 E. North Ave.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

Pulaski Va

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Pulaski Va Aug 18 1922

20-UNDERTAKER,

ADDRESS

Joseph Ahrens 221 Broadway

15- AUG 18 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66874

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66874

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL WARD)

2. FULL NAME

John Stuart MacDonald

(a) RESIDENCE NO.

115 Roland Ave ST. 37 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Resident

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds.

How long in U. S., if of foreign birth? 72 yrs. 11 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elizabeth Mary MacDonald

6 DATE OF BIRTH (month, day, and year)

Sept. 13-1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

11

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer)

Jewelry

(c) Name of employer

J. S. MacDonald Co

9 BIRTHPLACE (city or town) (State or country)

Huntington
Penn.

10 NAME OF FATHER

Robert MacDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Huntington
Penn.

12 MAIDEN NAME OF MOTHER

Sametta

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore
Maryland

14

Informant (Address)

JOHNS HOPKINS HOSPITAL
Baltimore

15

AUG 18 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1922, to Aug. 16, 1922, that I last saw him alive on Aug. 16, 1922, and that death occurred, on the date stated above, at 12⁰⁵ A. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(duration) 2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

Myocardial insufficiency (duration) 8 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test.

(Signed) W. H. Herman, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Elvith Cemetery Aug. 18, 1922

20 UNDERTAKER

STEVENS & MOORE
(WILLIAM F. MOORE, President)

ADDRESS

108 W. NORTH AVE.

STATE CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Shawley
HEALTH DEPARTMENT—CITY OF BALTIMORE
84 D 66875
CERTIFICATE OF DEATH.

D 66875
1-PLACE OF DEATH
City of BALTIMORE: (No. *1036 McDougall* St. *7* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Samuel H. Shawley*
(Residence in Baltimore: No. *1036 McDougall* St.; yrs. *48* mos. *—* ds.)

PERSONAL AND STATISTICAL PARTICULARS.		
3-SEX <i>Male</i>	4-COLOR OR RACE <i>White</i>	5-Single, married, widowed, or divorced. (Write the word.) <i>Married</i>
6-DATE OF BIRTH. <i>Sept 4 1877</i> (Month) (Day) (Year)		
7-AGE. <i>50 yrs. 11 mos. 13 ds.</i>		If LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Natural Gas</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>City of Balt.</i>		
9-BIRTHPLACE, (State or Country). <i>Oxford Md.</i>		
PARENTS.	10-NAME OF FATHER. <i>Edmund H. Shawley</i>	
	11-BIRTHPLACE OF FATHER. (State or Country). <i>Oxford Md.</i>	
	12-MAIDEN NAME OF MOTHER. <i>Mollie Greenley</i>	
	13-BIRTHPLACE OF MOTHER. (State or Country). <i>Oxford Md.</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Elizabeth Shawley wife*
(Address) *1036 McDougall*

15-
Filed *AUG 18 1922*
J. E. Vehn Registrar.

CORONER'S CERTIFICATE OF DEATH.	
16-DATE OF DEATH. <i>Aug 17 1922</i> (Month) (Day) (Year)	
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>inquest</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>inquest</i> (Inquest, autopsy or inquiry.) find that said deceased came to <i>his</i> death on the day stated above. The CAUSE OF DEATH* was as follows: <i>Angina Pectoris</i> (Duration) <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds. CONTRIBUTORY (Secondary) <i>Arteriosclerosis</i> (Signed) <i>J. E. Vehn</i> M. D. (Coroner) <i>Aug 18 1922</i> (Address) <i>508 E. Pratt St.</i> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds. In the State <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds. Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL. <i>Baltimore Cemetery</i> DATE OF BURIAL. <i>Aug 21 1922</i> 20-UNDERTAKER. <i>Henry Horck</i> ADDRESS <i>1301 E. Bay St.</i>	

D 66876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66876

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Amis Building General Hosp 24* ST. *24* WARD)

2-FULL NAME

Mrs Ida Linticum

(a) RESIDENCE NO.

1125 Light

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND or WIFE of

Willard G. Linticum

6 DATE OF BIRTH (month, day, and year)

Oct 7 1900

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*21**10**10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

At Home

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Henry Poffel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Ida Schults

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Willard G. Linticum 1125 Light St

15

AUG 18 1922

ROBERT R. KRAUTER, Registrar

Bucal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 17 1922*

17

I HEREBY CERTIFY, That I attended deceased from *August 2*, 1922, to *August 17*, 1922.that I last saw her alive on *August 17*, 1922,and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

hemorrhage (duration) yrs. mos. ds. *21*18 Where was disease contracted if not at place of death? *1125 Light St*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *William B. Dutton*, M. D.8/17, 1922 (Address) *817 Park Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Rosary Cemetery

DATE OF BURIAL

Aug 21 1922

20 UNDERTAKER

John F. Denny

ADDRESS

715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66877 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 403 N. Spring St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Thomas

(Residence in Baltimore: No. 403 N. Spring St.; yrs. mos. ds.)

3 Years in Balt

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Black 5-Single, Married, Widowed, or Divorced (Write the word.) Married

6-DATE OF BIRTH, 1. (Month) (Day) (Year)

7-AGE, 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Saleswoman (b) General nature of industry, business, or establishment in which employed (or employer) 641

9-BIRTHPLACE, (State or Country), Tennessee

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Husband

(Address) 403 N. Spring St

15- AUG 18 1922

Filed 192. J. H. Wehm Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) J. H. Wehm M. D.

(CORONER.)

8-17-22 (Address) 101 E. Pratt St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laural Linley Aug 19, 1922

20-UNDERTAKER, ADDRESS 1725-

Mrn Robert A. Elliot Oakland A

is very important. See instructions on back of certificate.

*Chloroform. Had had some heart trouble
before. Coroner could give no further history.
Nothing criminal. No accident.*

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyæmia, Childbirth, Gastritis, Necrosis, Septicæmia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66878

D 66878

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE: NO.

ST.: WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs 4 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thomas Jenkins

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 1927

(b) General nature of industry, business, or establishment in which employed (or employer)

House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Washington D.C.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Catharine Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Washington D.C.

14

Informant (Address)

Thomas Jenkins 715 N. Spring St.

15

Filed

AUG 18 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16-1922

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1922 to Aug 16, 1922, that I last saw her alive on Aug 16, 1922, and that death occurred, on the date stated above, at 4.40 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac disease

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

Address 822 N. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laural Cemetery

20 UNDERTAKER

Mrs Robert A. Elliott

DATE OF BURIAL

Aug 20 1922

ADDRESS 1725

Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificates.

D 66879 HEALTH DEPARTMENT—CITY OF BALTIMORE 66879

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 707 W. Jay Street - St. 3 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Rose

(Residence in Baltimore: No. 707 W. Jay Street St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, Single
(Write the word.)

6-DATE OF BIRTH, Don't Know
(Month) (Day) (Year)

7-AGE, 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer
(b) General nature of industry, business, or establishment in which employed (or employer), 40

9-BIRTHPLACE, (State or Country), France

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER, (State or Country), 1

12-MAIDEN NAME OF MOTHER, 1

13-BIRTHPLACE OF MOTHER, (State or Country), 1

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), S. Fournaros

(Address), 706 E. Balto. St.

15-Filed AUG 18 1922 J. E. Wehn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8-16-1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Inhalation of Chlorine Gas

(Duration) 1 yrs. mos. ds. a few hrs

CONTRIBUTORY (Secondary) Suicide

(Signed) J. J. Gorman M. D. (Coroner)
8-18-1922 (Address) 117 W. Sanborn St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Woodlawn Cemetery Aug 19 1922

20-UNDERTAKER, ADDRESS

J. J. Sander & Sons 1710 Fleet St.

is very important. See instructions on back of certificate.

D 66880

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ D 66880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 224 N. Biddle ST. 11 WARD)

2-FULL NAME

Alonzo Caesar

(a) RESIDENCE. NO.

224 N. Biddle

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

19

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 10 1909

7 AGE

13

Years

Months

3

Days

5

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

- 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Edward Caesar

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

May Pinderst

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

May Pinderst 224 N. Biddle St.

15

AUG 18 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 15 1922

17

HEREBY CERTIFY, That I attended deceased from Aug 14 1922 to Aug 15 1922 that I last saw him alive on Aug 15 1922and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary TuberculosisIndefinite

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Ex.(Signed) P. J. Garland M. D.Address) 1534 - Ohio St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Ambrose Cem Aug 17 1922

20 UNDERTAKER

ADDRESS

Saint Henry 224 N. Biddle

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66881

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant)

(Address)

15-

AUG 18 1922

ROBERT R. KRAUTER,

191

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 16 1922, to Aug 17 1922,

that I saw him alive on Aug 17 1922,

and that death occurred, on the date stated above, at 8:40 am.

The CAUSE OF DEATH* was as follows:

Defective Circulatory System

(Duration) yrs. mos. ds.

CONGESTIVE HEART FAILURE (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. W. H. D.

101... (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cem. Aug 18, 1922

20-UNDERTAKER

ADDRESS

Margaret G. Flynn 422 Right St.

important. See instructions on back of certificate.

D 66882 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 So. Calverton Rd. ST. 20 WARD)

2-FULL NAME George H. Bonhoff

(a) RESIDENCE No. 114 So. Calverton Rd. ST. 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie A. Bonhoff

6 DATE OF BIRTH (month, day, and year) Sept. 15 - 1866

7 AGE Years 55 Months 11 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)

10 NAME OF FATHER John Bonhoff

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Barbara Bonhoff

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14

Informant Mrs. Marie L. Drayner (Address) 114 So. Calverton Rd.

15 AUG 18 1922

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to August 15, 1922, that I last saw him alive on Aug. 15, 1922, and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

apoplexy
dropsy & Chronic Bright Disease
(duration) yrs. 2 mos. 2 ds.
CONTRIBUTORY dropsy & Bright Disease
(Secondary) (duration) yrs. 6 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. K. M. D.

Address 708 Enoch St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Ann's Cathedral

20 UNDERTAKER

George L. Schwalbe, 21 E. Pratt

DATE OF BURIAL

Aug 19 1922

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66883

CERTIFICATE OF DEATH.

113

D 66883

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 E 35th St

ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Edna Weber

(a) RESIDENCE. No. 704 E. 35th St.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 10 mos. 20 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 11 - 1922

7 AGE Years Months Days If LESS than 1 day. hrs. or min.

10 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

AUG 18 1922

ROBERT R. KRAUFER, Jr.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17th 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 10th 1922, to Aug 16th 1922, that I last saw her alive on Aug 16th 1922, and that death occurred, on the date stated above, at 11:30 A. M.

The CAUSE OF DEATH* was as follows:

Typhoid - Enteritis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

Pertussis

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy M. D.

, 19 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Aug 18 1922

20 UNDERTAKER

ADDRESS

Joseph Sykes 1600 W North St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

66884

PLACE OF DEATH

113 REGISTERED NO. 66884

CITY OF BALTIMORE (No. 608 S. Wolfe)

ST. 2 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME Josephine Stee

(Residence in Baltimore: No. 608 S. Wolfe St.)

St. yrs. 11 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6 DATE OF BIRTH September 24, 1921 (Month) (Day) (Year)

7 AGE 11 yrs. 11 mos. 24 ds. If LESS than 1 day, hrs. or min. 2

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Baltimore, Md.

10 NAME OF FATHER Michael Stee

11 BIRTHPLACE OF FATHER (State or country) Poland

12 MAIDEN NAME OF MOTHER Katherine Pschols

13 BIRTHPLACE OF MOTHER (State or country) Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Katherine Stee

(Address) 608 S. Wolfe St.

15

AUG 18 1922

ROBERT R. KRAUTER, REGISTRAR

Health Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH August 17, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1922, to August 17, 1922, that I saw her alive on August 17, 1922, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows: Ulcerative Stomatitis

(Duration) yrs. 1 mos. ds.

Contributory (SECONDARY) Diarrhea and Enteritis

(Duration) yrs. mos. 14 ds.

(Signed) M. Abramowitz M. D. Aug. 17, 1922 (Address) 1707 E. Baltimore St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted? If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. Stanislaw. DATE OF BURIAL Aug 19, 1922

20 UNDERTAKER M. J. Sadowski ADDRESS 408 S. ...

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 Aliceanna ST. 3 WARD)2-FULL NAME Stanislaw Kowalski(a) RESIDENCE NO. 1512 Aliceanna ST. 3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds.How long in U. S., if of foreign birth? 13 yrs. mos. ds.REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kataryna Kowalska6 DATE OF BIRTH (month, day, and year) Nov. 1, 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sutorer(b) General nature of industry, business, or establishment in which employed (or employer) 04(c) Name of employer Poland

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Stanislaw Kowalski11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland12 MAIDEN NAME OF MOTHER Julia Sokolowicz13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14

Informant (Address) 512 Aliceanna St.

15

AUG 18 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16, 192217 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1922 to Aug 16, 1922that I last saw him alive on Aug 15, 1922 and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Chronic Pericarditis
MyocarditisCONTRIBUTORY (Secondary) Cardiac Rupture (duration) 6 yrs. 6 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. H. Sauer, M. D.(Address) 1722 1st St. N. W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Stanislaw, Cem.DATE OF BURIAL Aug 19, 192220 UNDERTAKER M. J. SadowskiADDRESS 406 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66886

CERTIFICATE OF DEATH.

90 D 66886

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1733 Lancaster St. V WARD)

2-FULL NAME

Frank Wisniewski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1733 Lancaster St.

St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED, Married

6-DATE OF BIRTH,

Aug 14, 1894
(Month) (Day) (Year)

7-AGE,

28

If LESS than 1 day,

yrs. mos. ds.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cafe Tappan

9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER,

Frank Wisniewski

11-BIRTHPLACE OF FATHER
(State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Josephine Wisniewski

13-BIRTHPLACE OF MOTHER
(State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Josephine Orlikowski

(Address)

30 Bank St.

15-

AUG 18 1922

ROBERT R. KRAUTER,

101. Burial Permit Clerk
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 17, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb. 2 1922, to August 17 1922

that I saw h — alive on Aug 17 1922

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Valvular - Dis. of heart

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) 7 yrs. mos. 7 ds.

(Signed) J. H. Brown M. D.

Aug. 17, 1922 (Address) 12 S. Parkway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Stanislaus

DATE OF BURIAL,

Aug. 21, 1922

20-UNDERTAKER

M. J. Sadowski

ADDRESS

405 S. Andy

important. See instructions on back of certificate.

D 66887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 E Pratt St. 3 WARD)

2. FULL NAME

Emma L Willey

(a) RESIDENCE NO.

1407 E Pratt St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George W Willey

6 DATE OF BIRTH (month, day, and year) November 1855

7 AGE 67 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

York Pennsylvania

10 NAME OF FATHER

Geo Duly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

York Pennsylvania

12 MAIDEN NAME OF MOTHER

Margaret Eppley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

York Pennsylvania

14

Informant (Address)

Mrs Margaret Brady 1407 E Pratt St

15

Filed

AUG 16 1922

ROBERT R. KRAUTER

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 12, 1922, to Aug 16, 1922.

that I last saw him alive on Aug 16, 1922.

and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Martin, M. D.

19 (Address)

1222 Bunting

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Prospect Hill York Penn Aug 19 1922

20 UNDERTAKER

ADDRESS

John Howard & Son 901 Hollands

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102-N. Streeper ST., 6 WARD)

2-FULL NAME Elmer Lowner

(a) RESIDENCE NO. 102-N. Streeper ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

21

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27, 1922

7 AGE

Years

Months

Days

3 months

1922 July 27

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto mo (State or country)

10 NAME OF FATHER Carl Lowner

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Elsie Kalk

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14

Informant

(Address)

102 N. Streeper

AUG 18 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1922, to Aug 17, 1922,

that I last saw her alive on Aug 16, 1922,

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Acute Illness - Colitis

(duration)

yrs.

mos.

4 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John S. O'Brien, M.D.

19

(Address)

35-N. Potomac

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

William Cook

502 E. North

157130
557a.m.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66889

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Deloris Hamilton(a) RESIDENCE NO. 1330 Penn Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Child5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child6 DATE OF BIRTH (month, day, and year) April 16-19227 AGE Years Months Days If LESS than 1 day, hrs. or min. 4 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child(b) General nature of industry, business, or establishment in which employed (or employer) job

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D.C.10 NAME OF FATHER Mose Hamilton11 BIRTHPLACE OF FATHER (city or town) Va (State or country)12 MAIDEN NAME OF MOTHER Sarah Hamilton13 BIRTHPLACE OF MOTHER (city or town) D.C. (State or country)14 Informant JOHNS HOPKINS HOSPITAL

(Address)

15 AUG 18 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 192217 I HEREBY CERTIFY, That I attended deceased from Aug 11 1922 to Aug 15 1922 that I last saw her alive on Aug 15 1922 and that death occurred, on the date stated above, at 11 55 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhea not dysentery(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Home if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) T B Gay, M. D.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

AUG 18 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66890

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

ST., 76 WARD)

CITY OF BALTIMORE: (No.

2-FULL NAME

Baby Rigas

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 15 1922, to Aug. 16 1922.

that I last saw him alive on Aug. 16 1922.

and that death occurred, on the date stated above, at 9⁰⁵ A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed)

19

(Address)

Johns Hopkins Hospital.

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

ADDRESS

20 UNDERTAKER

14

Informant (Address)

15

Filed

AUG 18 1922

ROBERT R. KRAUTER

Registrar

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

PARENTS

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Steven Rigas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Greece

12 MAIDEN NAME OF MOTHER

Jane Cantoroso

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Greece

JOHNS HOPKINS HOSPITAL

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66891

CERTIFICATE OF DEATH.

D 66891

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL.**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. **9** ST., **9** WARD)2-FULL NAME **Baby King**(a) RESIDENCE NO. **1412 Hartford Ave.**

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female**Black****Baby**

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Baby6 DATE OF BIRTH (month, day, and year) **Aug. 15, 1922**

7 AGE

Years

Months

Days

If LESS than 1 day, 5 hrs. or 0 min.

0**0****0****0**

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Prince King

11 BIRTHPLACE OF FATHER (city or town) (State or country)

S. C.

12 MAIDEN NAME OF MOTHER

Gertrude Patterson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

Filed

19

AUG 18 1922**ROBERT R. KRAUTER,**
Registrar

Bridal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **Aug. 15, 1922**

17

I HEREBY CERTIFY, That I attended deceased from **Aug 15, 1922** to **Aug 15, 1922**, that I last saw her alive on **Aug 15, 1922**.and that death occurred, on the date stated above, at **3 p. m.**

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? **no** Date ofWas there an autopsy? **yes**

What test confirmed diagnosis?

(Signed) **W. W. Gray**, M. D.19 (Address) **Johns Hopkins Hospital.**

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

AUG 18 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66892

CERTIFICATE OF DEATH.

REGISTERED NO.

D 66892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Hayden(a) RESIDENCE NO. 703 S. Dallas St. ST. 3 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of John Hayden (or) WIFE of6 DATE OF BIRTH (month, day, and year) 18707 AGE Years 52 Months -- Days -- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)14 Informant Hospital Records (Address) Municipal Hospital

15 AUG 18 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 19 2217 I HEREBY CERTIFY, That I attended deceased from August 14, 19 22 to August 16, 19 22.that I last saw her alive on August 16, 19 22.and that death occurred, on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8/17/22Was there an autopsy? YesWhat test confirmed diagnosis? Clyde M. H. M. D.(Signed) Clyde M. H. M. D. M. D. 8/17/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL OakhillDATE OF BURIAL Aug 19, 19 2220 UNDERTAKER Jirke & JirkeADDRESS 738 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66893

HEALTH DEPARTMENT—CITY OF BALTIMORE

66893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2044 E Hoffman* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Lilli Steiner*(a) RESIDENCE. No. *2044 E Hoffman* ST., WARD.(Usual place of abode)
Length of residence in city or town where death occurred *44* yrs. *8* mos. *9* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *Widowed*6 DATE OF BIRTH (month, day, and year) *Apr 6 1877*7 AGE Years *44* Months *8* Days *9* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *William Reed*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Josephine Dutton*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va*14 Informant *Mrs. Ritz*
(Address) *2044 E Hoffman St*AUG 18 1922 19 REGISTRAR
Burial Permit Clerk *W. H. Krauter*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *May 1*, 19*22*, to *Aug 15*, 19*22*, that I last saw her alive on *Aug 15*, 19*22*, and that death occurred, on the date stated above, at *m.*
The CAUSE OF DEATH* was as follows:*Pulmonary Tuberculosis*(duration) *2* yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *John T. Avery*, M. D., 19 (Address) *1608 N Broadway*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery *Aug 19* 19*22*20 UNDERTAKER ADDRESS *1203**W. H. Krauter* *N. Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66894 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. BALTIMORE, MD.

ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clifford E. Brown,

(a) RESIDENCE NO. 635 HAW St., Baltimore, Md. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Black

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

--

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farm work

(b) General nature of industry, business, or establishment in which employed (or employer)

--

(c) Name of employer

--

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Unknown

14

Informant
(Address)

Hospital Records

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 19 22.

17

I HEREBY CERTIFY, That I attended deceased from
June 15, 19 22, to Aug. 17, 19 22.

that I last saw him alive on Aug. 17, 19 22.

and that death occurred, on the date stated above, at 8:50 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary tuberculosis, Far Advanced & Active

(duration)

yrs.

mos.

ds.

CONTRIBUTORY Pneumothorax, right side
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Date of

None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical, X-ray & Laboratory test.

(Signed)

Aug. 17, 1922 Address Ft. McHenry, Md.

Surgeon (R)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

National Cemetery 8/19/22

20 UNDERTAKER

ADDRESS

E. Harrison & Co. E. Balto St.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

181922

D 66895 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hosp. for women & nursery

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Loyette + John

ST.,

WARD)

2-FULL NAME

Mrs. Sarah H. Nichols

(a) RESIDENCE NO.

1828 Harlem ave.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

0 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm. H. Nichols

6 DATE OF BIRTH (month, day, and year)

July 25-1839

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

83

✓

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Kirkride Ricker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Rachel Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa

14

Informant (Address)

Samuel Mitchell
Baltimore, Md

AUG 18 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 18 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 2, 1922, to Aug 18, 1922.

that I last saw her alive on

Aug 18, 1922.

and that death occurred, on the date stated above, at

2:05 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

myocardial weakness

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

at place of death

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical examination

(Signed)

Thomas E. Tamm, M. D.

19

(Address)

Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Burial

Aberdeen, Md

Aug 18 1922

20 UNDERTAKER

ADDRESS

Wm J. Luckner, Son, N. Pa.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66896

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 WARD)

2-FULL NAME

(a) RESIDENCE NO. 317 Birchwood St.,

(Usual place of abode)
Length of residence in city or town where death occurred 47 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20, 1856

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant
(Address)

15

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17, 1922

I HEREBY CERTIFY, That I attended deceased from 8-10-1922, to 8-11-1922,

that I last saw him alive on 8-11-1922,

and that death occurred, on the date stated above, at 10:40 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Chronic Endocarditis
Serious Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. findings
(Signed) M. D.

(Address) Franklin D. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

81922

Burial Permit 616-1.

Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66897

D 66897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mr. Hope Robert*)ST. *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Sister Pacifica Stohler*(a) RESIDENCE. NO. *Danville, Pa.*ST. *28* WARD.*Danville Pa.*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *1* mos.

ds. How long in U. S., If of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Single*6 DATE OF BIRTH (month, day, and year) *March 21, 1865*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*57**5*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

Teaching

(c) Name of employer

9 BIRTHPLACE (city or town) *Waco, Minn.*

(State or country)

10 NAME OF FATHER

Albert Stohler

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Cath. Stohler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

*Friends of Mr. Hope Robert
Danville, Pa.*

15

Filed

*1922**Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8. 17. 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*July 15, 1922, to Aug 17, 1922.*that I last saw him alive on *Aug 17, 1922.*and that death occurred, on the date stated above, at *7. P. M.*

The CAUSE OF DEATH* was as follows:

*Valvular Heart Lesion**following attack of Flu*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Lung disease

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

at Danville, Pa.

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Chemical(Signed) *Charles S. Hile* M. D., 19 (Address) *Mr. Hope Robert*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Danville - Penna Aug 18, 1922**1922*

20 UNDERTAKER

ADDRESS

*STEWART & SONS**12 S. NORTH ST.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66898

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal tuberculosis Hosp. ST. 12 WARD)2. FULL NAME Curt Williams(a) RESIDENCE NO. 1807 Maryland ave.
(Usual place of abode)ST. 12 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofnot stated6 DATE OF BIRTH (month, day, and year) 18617 AGE Years 61 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER Reason Williams11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Sarah Donally13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Hospital records
(Address) M.T.H.15 Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 192217 I HEREBY CERTIFY, That I attended deceased from
May 28, 19 20, to Aug. 15, 1922.that I last saw him alive on Aug. 15, 1922.and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 2 yrs. 6 mos. ds.CONTRIBUTORY Chronic prostatitis with
(Secondary) obstruction (duration) 1 yrs. mos. ds.18 Where was disease contracted Unknown
if not at place of death?Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis J. Dadoyannis M. D.8-15-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Joseph Henry Matthews ✓
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66899

CERTIFICATE OF DEATH.

38 D 66899

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hospit. 16* WARD)

2-FULL NAME *Matthews, Joseph Henry*

(a) RESIDENCE NO. *?*

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed,
or Divorced, (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

?

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

34

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

?

087

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

?

10 NAME OF FATHER

?

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

?

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

?

14

Informant
(Address)

15

Filed

Robert P. Harrison,

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 15 1922*

17

I HEREBY CERTIFY, That I attended deceased from
August 4, 1922, to Aug 15, 1922,
that I last saw him alive on *Aug. 14, 1922,*
and that death occurred, on the date stated above, at *4:30 a.m.*

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

CONTRIBUTORY *Leuc. Chronic Gastritis*
(duration) *?* yrs. mos. ds.
(Secondary)
ritis (duration) *8* yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical & Laboratory*
(Signed) *H. Goldsmith* M. D.
, 19 (Address) *Bay View Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health

AUG 16 1922

181922

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66900

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

131 D 66900

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2109 Lyndhurst Ave ST. 15 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2109 Lyndhurst Ave)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str: 36 yrs. 2 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15

Robert P. Harrison,

Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed),

Aug 17, 1922 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66901

D 66901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 W. Saratoga ST., 20 WARD)

2-FULL NAME George Westerman Heddrick

(a) RESIDENCE No. 1825 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1849

7 AGE Years 73 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Retiree

(a) Trade, profession or particular kind of work Painter & Enameler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania (State or country)

10 NAME OF FATHER George Heddrick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Jane Westerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant Mrs. Ernest R. Hall (Address) 1825 W. Saratoga St.

15

Filed

Robert P. Harrison, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept-19, 1921, to Aug 17, 1922, that I last saw him alive on Aug 17, 1922.

and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis (duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Uræmic coma (duration) yrs. mos. 11 hrs.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis (Signed) Benj. F. Phillips, M. D.

Aug 18, 1922 (Address) 1929 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

20 UNDERTAKER

George J. Smith

DATE OF BURIAL

Aug 18 1922

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922

Burial Permit Clerk.

D 66902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 4 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ira W. Redden.(Residence in Baltimore: No. State Normal School, Towson, Md. St.; yrs. 4 mos. ----- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male. 4-COLOR OR RACE White. 5-Single, Married, Widowed, or Divorced. Single.
(Write the word.)6-DATE OF BIRTH. Do not know. 1.....
(Month) (Day) (Year)7-AGE 44 yrs. ----- mos. ----- ds. If LESS than 1 day, ----- hrs. or ----- min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Fireman.
(b) General nature of industry, business, or establishment in which employed (or employer) State Normal School.9-BIRTHPLACE, (State or Country), Worcester Co. Md.PARENTS.
10-NAME OF FATHER, William I. Redden.
11-BIRTHPLACE OF FATHER, (State or Country), Worcester Co. Md.
12-MAIDEN NAME OF MOTHER, Charlotte Mitchell.
13-BIRTHPLACE OF MOTHER, (State or Country), Worcester Co. Md.14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James B. Richardson. (cousin)
(Address) State Normal School, Towson, Md.15- Robert P. Harrison,
Filed 18 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 18th, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
struck by car of U. Ry. & E. Co.
Accidental death.
(Duration) ----- yrs. ----- mos. ----- ds.CONTRIBUTORY (Secondary) ----- (Duration) ----- yrs. ----- mos. ----- ds.
(Signed) W. H. Penhance M. D.
(Coroner.)Aug. 18th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ----- yrs. ----- mos. ----- ds. In the State ----- yrs. ----- mos. ----- ds.Where was disease contracted, if not at place of death? Work Rd. opp. State Normal School
Former or usual residence Aug. 17th. 1922.19-PLACE OF BURIAL OR REMOVAL Indlewood, Worcester Co. Md. DATE OF BURIAL Aug 21, 192220-UNDERTAKER George J. Smith ADDRESS 509 25

is very important. See instructions on back of certificate.

66903

HEALTH DEPARTMENT—CITY OF BALTIMORE

66903

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *U. P. D.* St. *22* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *803 Sharp St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced. (Write the word.) *married*6-DATE OF BIRTH, *about* 19*17* (Month) (Day) (Year)7-AGE, *about* 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer), *R. R. 040*9-BIRTHPLACE, (State or Country), *Russia*PARENTS. 10-NAME OF FATHER, *Y. M. ...* 11-BIRTHPLACE OF FATHER, (State or Country), *...* 12-MAIDEN NAME OF MOTHER, *...* 13-BIRTHPLACE OF MOTHER, (State or Country), *...*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *C. N. Stambough* (Address) *Westminister, Md.*15- *Robert P. Harrison,*

191822

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 14*, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above. The CAUSE OF DEATH* was as follows:*Fracture of Skull*(Duration) yrs. mos. ds. *3 hrs.*CONTRIBUTORY (Secondary) *R. R. accident* (Duration) yrs. mos. ds.(Signed) *J. T. Hennessey* M. D. (Coroner.)*Aug 18* 1922 (Address) *280 E. ...*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place *U. P. D.* In the of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted, if not at place of death? *at home to W. M. R. R.*Former or usual residence *903 Sharp St.*19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *St. Mary's Hospital Aug 19*, 192220-UNDERTAKER, ADDRESS *W. M. ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66904

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 Riggs ave ST. 16 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

47 yrs.

mos.

ds.

How long in U. S.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Geo. W. Barker

6 DATE OF BIRTH (month, day, and year)

June 11, 1847

7 AGE

75 Years

Months

2

Days

7

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Anna Arundel C. Md.

10 NAME OF FATHER

James Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Stinchcomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14 Informant (Address)

Tom E. Barker
2606 Riggs ave.

1922

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1922, to Aug. 18, 1922, that I last saw her alive on Aug. 18, 1922, and that death occurred, on the date stated above, at 7.25 a.m. The CAUSE OF DEATH* was as follows:

Nephritis - with En-
cephalitis of Age.

CONTRIBUTORY (Secondary)

Apoplexy - Paralysis -
(duration) 4 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Home -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? General Clinical Imp.
(Signed) Wm. M. Pannemaker, M. D.

19 (Address) 1209 Madison ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Johns Rd

20 UNDERTAKER

Wm Cook

DATE OF BURIAL

Aug. 21 1922

ADDRESS

W. G. K.

Burial Permit cleared

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66906

CERTIFICATE OF DEATH.

31 D 66906

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Rosa Woodhouse(a) RESIDENCE NO. 619 Lafayette ave. ST. 17 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced, HUSBAND of Arthur Woodhouse (or) WIFE of Not given6 DATE OF BIRTH (month, day, and year) 19057 AGE Years 17 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

North Carolina10 NAME OF FATHER Charles Moore

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

North Carolina12 MAIDEN NAME OF MOTHER Anna Hagens

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

North Carolina

14

Informant Hospital Records(Address) M.T.H.

15

AUG 19 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1922

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1922, to Aug. 17, 1922,

that I last saw him alive on Aug. 17, 1922,

and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 7 mos. ds.CONTRIBUTORY Tuberculosis of right kidney (Secondary) (duration) yrs. 3 mos. ds.18 Where was disease contracted Unknown if not at place of death?Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis T.B. in sputum, X-ray(Signed) Francis D. Dadd M. D.8-17-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

8-19-22

20 UNDERTAKER

ADDRESS

1400 M. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 66907

CERTIFICATE OF DEATH.

90 D 66907

1-PLACE OF DEATH

City of BALTIMORE: (No. *on Street Cap. Baths'* St. *19* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1629 N Fayette St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH.

*Jan**21**1900*

7-AGE.

72

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)*none*

9-BIRTHPLACE, (State or Country).

Bath City

10-NAME OF FATHER.

John H. Shodtman

11-BIRTHPLACE OF FATHER, (State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Don't know

13-BIRTHPLACE OF MOTHER, (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Shodtman

(Address)

1629 N Fayette St

15-

FEB

AUG 19 1922

192

ROBERT B. KRAUTER

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Aug**17**1922*17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) *Don't know* yrs. mos. ds.CONTRIBUTORY (Secondary) *Don't know*(Signed) *H. H. Gonsiel* M. D. (Coroner.)*8-19* 1922 (Address) *117 N. Varadero*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baths

DATE OF BURIAL.

Aug 20 1922

20-UNDERTAKER.

John J. Fields 1200 N. Lombard

ADDRESS

is very important. See instructions on back of certificate.

D 66908

HEALTH DEPARTMENT—CITY OF BALTIMORE

66908

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 2927 Guilford Ave

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Samuel H. Coulbourn

(a) RESIDENCE NO.

2927 Guilford Ave ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Wh

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lydia R Coulbourn

6 DATE OF BIRTH (month, day, and year)

Mch 27, 1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

4

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Oyster Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hopewell Md

10 NAME OF FATHER

Wm C Coulbourn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Ann

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Joseph C Coulbourn 2927 Guilford Ave

AUG 19 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1922

17

I HEREBY CERTIFY, That I attended deceased from August 13, 1922, to August 18, 1922.

that I last saw him alive on Aug 18, 1922

and that death occurred, on the date stated above, at 728 P. m.

The CAUSE OF DEATH* was as follows:

Blood clot on the brain

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 6

(duration) yrs. mos. ds. 6

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd D. Green, M. D.

19 (Address) 1127 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Wood Ridge Aug 19 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 1120 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66909 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Off south end of
City of BALTIMORE: (No. Hanover St. Bridge. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME (Joseph) Zachari Naumchuk.
(Residence in Baltimore: No. 942 Burgundy St. St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Do not know. (Month) (Day) (Year)

7-AGE, 29 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Fireman. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Paranka Naumchuk. (wife). (Address) 942 Burgundy St.

15- AUG 19 1922 ROBERT H. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned while in swimming.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Aug. 13, 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

is very important. See instructions on back of certificate.

THE MORRIS 19445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66910

CERTIFICATE OF DEATH.

199th D 66910

1-PLACE OF DEATH

City of BALTIMORE (No. *Lombard St 76*)

Registered No. C.

Ward) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *3716 Foster Ave*)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-Single, Married, Widowed, or Divorced. *Married* (Write the word.)6-DATE OF BIRTH. *May 23rd* 188*2* (Month) (Day) (Year)7-AGE. *40* yrs. *2* mos. *16* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Bus Driver* (b) General nature of industry, business, or establishment in which employed (or employer). *Same*9-BIRTHPLACE, (State or Country). *MD*10-NAME OF FATHER. *Wm L. Coulbourn*11-BIRTHPLACE OF FATHER, (State or Country). *DEL*12-MAIDEN NAME OF MOTHER. *Mary A. Groves*13-BIRTHPLACE OF MOTHER, (State or Country). *Balto Co. Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). *Mary A. Coulbourn*(Address). *3716 Foster Ave*

15-AUG 19 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Aug 16th* 192*2* (Month) (Day) (Year)17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Autopsy* (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said *Autopsy* and that said deceased came to *death* (topsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart (Duration) yrs. mos. ds.CONTRIBUTORY *Has been & thrown* (Secondary) (Duration) yrs. mos. ds.(Signed) *John P. Gordon* M. D. (Address) *Curtis Bay**State the Disease Causing Death, or, if death from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. *MD*

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. *Facred Heart Am* DATE OF BURIAL. *Aug 19* 192*2*20-UNDERTAKER. *Lilly & Zick* ADDRESS *403 S. Wolfe*

D 66911

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66911

CERTIFICATE OF DEATH.

159-003

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *268 S. Robinson* ST., *1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Thomas. Tosches.

(a) RESIDENCE NO.

*268 S. Robinson St.*ST., *1* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male
Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 1 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Pasquale Tosches

11 BIRTHPLACE OF FATHER (city or town)

Italy

(State or country)

12 MAIDEN NAME OF MOTHER

Carolina Tosches

13 BIRTHPLACE OF MOTHER (city or town)

New Jersey

(State or country)

14

Informant (Address)

Pasquale Tosches 268 S. Robinson St.

15

AUG 19 1922

Filed

19

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 18 1922

17

I HEREBY CERTIFY, That I attended deceased from *August 1*, 1922 to *August 17*, 1922that I last saw him alive on *Aug 17*, 1922and that death occurred, on the date stated above, at *11:40 P. m.*

The CAUSE OF DEATH* was as follows:

*Heart - Lung
due to Spina - Bifida*
(duration) yrs. mos. *18* ds.

CONTRIBUTORY (Secondary)

Insufficient
(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Dr. L. H. Williams* M. D.1922 (Address) *2 N. Perry*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Holy Redeemer Ch

DATE OF BURIAL

Aug 19 1922

20 UNDERTAKER

Lilly and Zeile

ADDRESS

403 S. W. 1st

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66912

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66912

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 Light ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 1624 Light St

(Usual place of abode)

ST., 23 WARD

Length of residence in city or town where death occurred

yrs. 2 mos. 7 ds.

How long in U. S., if of foreign birth?

yrs. 1 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) June 12, 19227 AGE Years 2 Months 8 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bethesda, Md
(State or country)10 NAME OF FATHER William Gardner11 BIRTHPLACE OF FATHER (city or town) Bethesda, Md
(State or country)12 MAIDEN NAME OF MOTHER Elizabeth Gardner13 BIRTHPLACE OF MOTHER (city or town) Bethesda, Md
(State or country)

14

Informant
(Address) William Gardner

15

Filed

AUG 19 1922

Registrar J. E. Welch

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 19 2217 I HEREBY CERTIFY, That I attended deceased from August, 19 17, to August 17, 19 22.that I last saw him alive on August 17, 19 22.and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Acute EnteritisCONTRIBUTORY (Secondary) Malnutrition
(duration) yrs. 2 mos. 1 ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

(Signed) John A. Connor, M. D., 19 22 (Address) 4904 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 66913**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2006 Bolton ST. 10 WARD)

2-FULL NAME

Winnie Schneeberger(a) RESIDENCE NO. 2006 Bolton ST. 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Schneeberger6 DATE OF BIRTH (month, day, and year) June 19 18 457 AGE Years 77 Months 2 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Hertz Wertheim11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Brina Katz13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) Mrs. S. Jacobs, Catonsville, Md.

15

Filed

19

J. Wehm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/2217 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Aug 18, 1922, that I last saw him alive on Aug 17, 1922, and that death occurred, on the date stated above, at 69 m.

The CAUSE OF DEATH* was as follows:

Hodgkins diseaseCONTRIBUTORY (Secondary) Myocarditis (duration) yrs. 6 mos. ds.18 Where was disease contracted ✓ if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical (Signed) 7 Frederick Lutz, M. D.8/19, 1922 (Address) 2040 Eutan Plau

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Beth Hebrew Cem 8/20/22

20 UNDERTAKER

David Sandheim 118 No. Mt. Royal Ave.

D 66914

HEALTH DEPARTMENT—CITY OF BALTIMORE

66914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Letter Johns of the Prov.* 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Thomas Connolly*(a) RESIDENCE. NO. *Frost Valley St.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Male**White**Widower*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Sabrina Steeler*

6 DATE OF BIRTH (month, day, and year)

1841

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*81*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Ireland*

10 NAME OF FATHER

Michael Connolly

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Margaret Cameron

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

(Address)

*Sister Florence
Letter Johns of the Prov.*

15

Filed

19

*AUG 19 1922**H. H. Wilson*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 18* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

to record

19

to

19

that I last saw him alive on *Aug 17*, 1922and that death occurred, on the date stated above, at *6.30 P.m.*

The CAUSE OF DEATH* was as follows:

*Arterio sclerosis**Unknown*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. H. Wilson

M. D.

1922 Address)

1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral**Aug 19 1922*

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Greenmilk St.

CRUELTY OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 66915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital*ST.: *7*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ellice Virginia Morgan

(a) RESIDENCE. NO.

16 Midship Road,

ST.

WARD.

Seabrook, Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

January 11, 1921

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*1**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore, Maryland.*

10 NAME OF FATHER

*Harry L. Morgan.*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Shatham, N.J.*

12 MAIDEN NAME OF MOTHER

*Grace Virginia Meyer*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Richmond, Virginia*

14

Informant
(Address)*Harry L. Morgan
16 Midship Road, Seabrook, Md.*

AUG 19 1922

ROBERT N. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from

*August 18, 1922, to August 18, 1922.*that I last saw him alive on *August 18, 1922.*and that death occurred, on the date stated above, at *10:15 P.M.*

The CAUSE OF DEATH* was as follows:

Intero Colitis

(duration)

yrs.

mos.

ds. *12*CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds. *1*18 Where was disease contracted
if not at place of death?*Home*

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Stomach

(Signed)

Moses Gellman

, M. D.

, 19

(Address)

Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Oak Lawn Cem**Aug 21 1922*

20 UNDERTAKER

John Hellrich

ADDRESS

2008 Calver

TION is very important. See instructions on back of certificates.

Sucha. HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66916

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Patterson Park Ave ST., 6 WARD)

2. FULL NAME

Frederick W. Sucha

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 412 N. Patterson Park Ave ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

Augusta Sucha

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

AUG 19 1922

ROBERT M. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

April 29, 1922, to Aug 17, 1922that I last saw him live on Aug 17, 1922and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart -(duration) 1 yrs. 2 mos. 27 ds.

CONTRIBUTORY (Secondary)

General Anasarca(duration) 2 yrs. 2 mos. 27 ds.18 Where was disease contracted if not at place of death? at homeDid an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Physical signs(Signed) Chas. S. Neer, M. D., 19 (Address) 408 S. Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66917 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66917

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE, MD.

312 N. Guilford ST.

WARD 19

2. FULL NAME

Chiah Mitchell

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

312 N. Guilford ST.

WARD

Length of residence in city or town where death occurred

1 yr.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar. 16-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

OOD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

James Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Nellie Talbot

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

James Mitchell, 312 N. Guilford ST.

AUG 19 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 16, 1922, to Aug 17, 1922,

that I last saw him alive on Aug 17, 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Prolapse rectum & Drunken

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

if not at place of death? 312 N. Guilford ST.

Did an operation precede death? Prolapse reduced Date of Aug 16 22

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Herman J. Dorf, M. D.

19 (Address) 3730 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

St. Vincent's Cemetery

Aug 19 1922

20 UNDERTAKER

ADDRESS 58

Saint Vincent's Burial

Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66918

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *510 N. West* ST. *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Ruth Rainey*(a) RESIDENCE. No. *510 N. West St* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *2*mos. *24*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*X*6 DATE OF BIRTH (month, day, and year) *8/25/22*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*2**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *James Rainey*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Jamworth Va.*12 MAIDEN NAME OF MOTHER *Harnett Roeloffs*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Goodland Co. Va.*

14

Informant (Address) *Mrs. Harnett Rainey 5 E. Lee St*

15

AUG 19 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8/18* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

8/17, 19 *22*, to *8/18*, 19 *22*.that I last saw her alive on *8/18*, 19 *22*.and that death occurred, on the date stated above, at *4.30 P.* m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis(duration) yrs. mos. *10* ds.CONTRIBUTORY (Secondary) *Broncho-Pneumonia*(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Dr. A. Harris*, M. D.*8/19, 1922* (Address) *1200 Penn Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt Auburn Ct.**Aug 19 1922*

20 UNDERTAKER

ADDRESS

*J. B. Brownell Son**118 N. Main St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

66919

CERTIFICATE OF DEATH.

114 D 66919

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Med. Gen. Hosp. 12* ST.: *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Bessie Morris*(a) RESIDENCE. NO. *3102 Auden Toroly Terrace* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *44* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *— 1878*7 AGE Years *44* Months *3* Days *0* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *England* (State or country)10 NAME OF FATHER *George S Morris*11 BIRTHPLACE OF FATHER (city or town) *England* (State or country)12 MAIDEN NAME OF MOTHER *Tamer Prutia*13 BIRTHPLACE OF MOTHER (city or town) *England* (State or country)14 Informant *Med. Gen. Hosp. Records* (Address)15 *AUG 19 1922* *ROBERT R. KRAUTER,* Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8/18/22* 1917 I HEREBY CERTIFY, That I attended deceased from *4/23/22*, 19, to *8/18/22*, 19.that I last saw her alive on *8/18/22*, 19, and that death occurred, on the date stated above, at *11:20 PM*.

The CAUSE OF DEATH* was as follows:

*Immunity*CONTRIBUTORY (Secondary) *Enteric Colitis (Typhoid)* (duration) yrs. *3* mos. *18* ds.(duration) *2 1/2 yrs.* 3 mos. *18* ds.18 Where was disease contracted if not at place of death? *—*Did an operation precede death? *—* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Culture of Lys. B. 1922*(Signed) *A. Thompson* M. D.19 (Address) *Inden Street*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge Cemetery *8/21, 1922*

20 UNDERTAKER ADDRESS

Henry W. Mears & Son 805 N. Calvert

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 66920

D 66920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 N Rose ST.; 8 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Madeline C. Daliso(Residence in Baltimore: No. 1304 N. Rose St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

7

4-COLOR OR RACE,

W5-SINGLE,
MARRIED, 8
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Aug 12, 1922
(Month) (Day) (Year)

7-AGE,

yrs. mos. 6 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),Baltimore City

10-NAME OF FATHER,

Samuel Daliso11-BIRTHPLACE OF FATHER
(State or Country),Italy

12-MAIDEN NAME OF MOTHER

Annella Franciscetta13-BIRTHPLACE OF MOTHER
(State or Country),Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Daliso(Address) 1304 N Rose

15-

Filed..... 191... ROBERT R. KRAUTER...

Registrar.

AUG 19 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 17 1922, to Aug 18 1922that I saw her alive on Aug 18 1922,and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Samuel Daliso(Duration) yrs. mos. 6 ds.CONTRIBUTORY... Spontaneous
(Secondary)(Duration) yrs. mos. 1 ds.(Signed) Mrs. L. Daliso M. D.Aug 17, 1922 (Address) Mrs. L. Daliso

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St Vincent Cem Aug 19, 1922

20-UNDERTAKER

ADDRESS

Frank A. Tink 915 N. Gay St

66921

HEALTH DEPARTMENT—CITY OF BALTIMORE

66921

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2713 Atkison Ave WARD)

2-FULL NAME

Charles R Carroll Jr

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2713 Atkison Ave

WARD

(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) Sept 21 19217 AGE 11 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) Ind

10 NAME OF FATHER

Charles R Carroll11 BIRTHPLACE OF FATHER (city or town, State or country) Ind

12 MAIDEN NAME OF MOTHER

Anna Chalk13 BIRTHPLACE OF MOTHER (city or town, State or country) Ind

14

Informant
(Address)Anna Carroll
2713 Atkison Ave

15

Date

AUG 19 1922ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 192217 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1922, to Aug 18, 1922, that I last saw him live on Aug 18, 1922, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)Chorea Infantum
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Balto Leem Aug 19 22
Chenoweth Sen Chestnut

66922 HEALTH DEPARTMENT—CITY OF BALTIMORE 66922

D 66922

CERTIFICATE OF DEATH.

31 D 66922

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017 & Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary J Silk

(a) RESIDENCE NO.

3017 & Monument ST., 9 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James E Silk

6 DATE OF BIRTH (month, day, and year)

May-1895

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

3

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

037

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Ferdinand H Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

James E Silk

15

Robert P. Harrison,

, 19

Registrar

20 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1922

17

HEREBY CERTIFY That I attended deceased from

Jan 1, 1922, to Aug 17, 1922,

that I last saw her alive on Aug 17, 1922,

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 9/20

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) J. H. Schuler, M. D.

8/17, 1922 (Address) 3307 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Redeemer

Aug 21 1922

20 UNDERTAKER

ADDRESS

Geo M. Finkelson

811 N. Wolfe

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Agout Hope Retrial* ST. *288* WARD)2-FULL NAME *William J. Connolly*(a) RESIDENCE. NO. *Agout Hope Retrial* ST. *288* WARD. *Baltimore*

(Usual place of abode)

Length of residence in city or town where death occurred *0* yrs. *0* mos. *14* ds. How long in U. S., if of foreign birth? *—* yrs. *—* mos. *—* ds.REGISTERED NO. *75-007*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *of Mrs Connolly*

6 DATE OF BIRTH (month, day, and year)

7 AGE *abt* Years *72* Months *0* Days *0* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *E. Bartender -*(b) General nature of industry, business, or establishment in which employed (or employer) *044*

(c) Name of employer

9 BIRTH (city or town) *Baltimore* (State) *MD*10 NAME OF FATHER *Not Known*11 BIRTHPLACE OF FATHER (city or town) *Not Known* (State or country) *" "*12 MAIDEN NAME OF MOTHER *Not Known*13 BIRTHPLACE OF MOTHER (city or town) *Not Known* (State or country) *" "*14 Informant *Records of Mt Hope Retrial* (Address) *Mt Hope Retrial - Baltimore*15 Filed *20* 1922 *Robert P. Harrison, Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 18* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 3rd* 19 *22*, to *Aug 18* 19 *22*, that I last saw *him* alive on *Aug 18* 19 *22*, and that death occurred, on the date stated above, at *6:30 P.* m.

The CAUSE OF DEATH* was as follows:

*Paralysis (Cor Arterio-sclerosis)**abt* (duration) yrs. *—* mos. *4* ds.CONTRIBUTORY *Dementia Senile* (Secondary) (duration) *7* yrs. *0* mos. *0* ds.18 Where was disease contracted *Baltimore* if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Frank J. Flannery, M. D.*, 19 (Address) *Agout Hope Retrial*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *St. Marys Cem Gorans* DATE OF BURIAL *21* 19 *22*20 UNDERTAKER *George J. Puth* ADDRESS *1235*

Burial Permit Clerk

TION is very important. See instructions on back of certificates.

~~66723~~
D 66924

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~01 66723~~
D 66924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *525 So. Caroline St* Ward)

Registered No. C.

2-FULL NAME

(Residence in Baltimore: No. *525 So. Caroline St* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(3)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Black* 5-Single, Married, Widowed, or Divorced, (Write the word) *Single*

6-DATE OF BIRTH, *Unknown* 1901
(Month) (Day) (Year)

7-AGE, *21* *Adult* If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Auto Mechanic*
(b) General nature of industry, business, or establishment which employed (or employer)

9-BIRTHPLACE, (State or Country), *N.C.*

10-NAME OF FATHER, *Albert Lewis*

11-BIRTHPLACE OF FATHER, (State or Country), *N.C.*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER, (State or Country), *N.C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph Lewis*

(Address) *Rocky Mt*

15- Robert P. Harrison, Registrar.

20-1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 17* 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) *2 weeks*

CONTRIBUTORY (Secondary) *Sho D. Horton*
(Signed) *Curtis Bay*
(Address) *1200 N. ...*
State the Disease Causing Death in deaths from violence, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Rocky Mt N.C.* DATE OF BURIAL, *Aug 21*

20-UNDERWRITER, *Chris. N. Johnson* ADDRESS, *416 N. Cordia*

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. *567 Baker*ST.: *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Wm Barham*(a) RESIDENCE. No. *567 Baker*

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. *15* mos.

ds. (How long in U. S., if of foreign birth?)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *mail* 4 COLOR OR RACE *col* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1886*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *36*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Sabor*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *ne*10 NAME OF FATHER *unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *ne*12 MAIDEN NAME OF MOTHER *unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *ne*14 Informant *Aunie Barham* (Address) *567 Baker St*15 Date of death *8/18/22*

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8/18* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from

8/17 19*22* to *8/18* 19*22*that I last saw him alive on *8/18* 19*22*and that death occurred, on the date stated above, at *5:45* m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Ben R. Smith* M. D.19 (Address) *2139 Dill Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt Auburn Cemetery**8/21/22*

20 UNDERTAKER

ADDRESS

Robert E. Williams 1116 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

20 1922

157814
D 66926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66926

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (In JOHNS HOPKINS HOSPITAL ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Willard A. Rill(a) RESIDENCE NO. Johns Hopkins Hospital

(Usual place of abode)

WARD Syracuse N.Y.

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

3

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofLillian D. Rill

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.4822

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)New York

10 NAME OF FATHER

Adrian L. Rill11 BIRTHPLACE OF FATHER (city or town)
(State or country)New York

12 MAIDEN NAME OF MOTHER

Christine L. Marlin13 BIRTHPLACE OF MOTHER (city or town)
(State or country)New York

14

Informant
(Address)JOHNS HOPKINS HOSPITAL

15

Filed

19

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 16, 19 22, to Aug 19, 19 22that I last saw him alive on Aug. 19, 19 22,and that death occurred, on the date stated above, at 10:15 p.m.

The CAUSE OF DEATH* was as follows:

Brain tumor - left cerebral -
pineal region -Symptoms(duration) yrs. 5 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Syracuse, N.Y.Did an operation precede death? Yes Date of Aug. 19 22Was there an autopsy? Partial - HeadWhat test confirmed diagnosis? Air injection(Signed) A. L. Reichert, M. D.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Syracuse, N.Y. Aug 20 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 66927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66927

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Barclay ST. 12 WARD)

2-FULL NAME

Sallie Corbett

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1909 Barclay

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James B Corbett

6 DATE OF BIRTH (month, day, and year)

Oct 23 1882

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harford Co Md

10 NAME OF FATHER

John H Dierker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Dierker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Holland

14

Informant

(Address)

Leo Corbett

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 17, 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 28, 1922, to Aug 17, 1922

that I last saw her alive on Aug 16, 1922

and that death occurred, on the date stated above, at 6:45 p. m.

The CAUSE OF DEATH* was as follows:

Coronary Sclerosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John J. Dierker, M. D.

(Address) 935 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mountain Christian Church

Aug 20 1922

20 UNDERTAKER

Harford Co Md

ADDRESS

William Cook

606 North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66928

CERTIFICATE OF DEATH.

REGISTERED NO. C 66928

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 E. Olney ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Caroline Morris

(Residence in Baltimore: No. 2310 E. Olney ST., yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-MARITAL.

WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

June 26, 1882
(Month) (Day) (Year)

7-AGE,

40 yrs. 1 mos. 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife 037
Rubber

9-BIRTHPLACE,

(State or Country).

Maryland

10-NAME OF FATHER,

Andrew Weatherston

11-BIRTHPLACE OF FATHER (State or Country).

Maryland

12-MAIDEN NAME OF MOTHER

Ellen Lindhold

13-BIRTHPLACE OF MOTHER (State or Country).

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Morris

(Address) 2310 E. Olney St.

15-

Robert P. Harrison,

Filed..... 191.....

20-UNDERTAKER Burial Permit Clerk. Registrar.

1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 18, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 17, 1912, to Aug 18, 1912,

that I saw him alive on Aug 18, 1912,

and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY Inter-tracheal phlegm (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. E. Harrison M. D.

Aug 19, 1912 (Address) 1301 N. Patton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery Aug 26, 1912

20-UNDERTAKER

ADDRESS

Isaac Soper 1600 W. North

D 66929

HEALTH DEPARTMENT—CITY OF BALTIMORE

66929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *912 Stiles* St., *3* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *912 Stiles St*)

St.; yrs.,..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married* (Write the word.)6-DATE OF BIRTH, *Oct 29*, 18*57* (Month) (Day) (Year)7-AGE, *64* yrs., *8* mos., *19* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Cabinet maker* (b) General nature of industry, business, or establishment in which employed (or employer), *014*9-BIRTHPLACE, (State or Country), *Italy*10-NAME OF FATHER, *Alfonso Alvigi*11-BIRTHPLACE OF FATHER, (State or Country), *Italy*12-MAIDEN NAME OF MOTHER, *Agnes Rees*13-BIRTHPLACE OF MOTHER, (State or Country), *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1922

Robert P. Harrison,

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 18*, 192*2* (Month) (Day) (Year)17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* find that said deceased came to *his death* (topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy at one (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Thos. B. Norton* M. D. (Coroner) *Aug 18*, 192*2* Address *Certus Bay*

*State the Disease Causing Death, or death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St Vincent* DATE OF BURIAL, *Aug 21*, 192220-UNDERTAKER, *Wandell Dwyer*ADDRESS *328 Ave*

is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66930

D 66930

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 17 W Chapel ST., 6 WARD)

2-FULL NAME

Anna Weindecker

(a) RESIDENCE NO.

17 W ChapelST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofHenry Weindecker

6 DATE OF BIRTH (month, day, and year)

March 14 1851

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.7154

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

800

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Dont know11 BIRTHPLACE OF FATHER (city or town)
(State or country)Germany

12 MAIDEN NAME OF MOTHER

Dont know13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Germany

14

Informant
(Address)Anna Weindecker
17 W ChapelRobert P. Harrison

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1922

17

I HEREBY CERTIFY, That I attended deceased from
January, 1921 to Aug. 17, 1922.
that I last saw her alive on Aug 14, 1922.and that death occurred, on the date stated above, at 8:30 A m.
The CAUSE OF DEATH* was as follows:Broncho-Pneumonia(duration) yrs. 1 mos. 7 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Aug. 19 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALHoly Redeemer

20 UNDERTAKER

Wendell Dyfel son

DATE OF BURIAL

Aug 21 1922

ADDRESS

378 m

Exact statement of Occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66931

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2115 E Fairmont ST., 6 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 5 mos.

ds.

How long in U. S., if of foreign birth?

yrs. 5 mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 28/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Milton Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Ada

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E Baltimore

15

led

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/10/22

17

I HEREBY CERTIFY, That I attended deceased from

8-18-1922 to 8-28-1922

that I last saw her alive on 8-19-22, 1922

and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease (valvular)

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Hebrew Home for the Aged 8/20/22 Jack Lewis 1439 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66932

CERTIFICATE OF DEATH.

90 D 66932

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 S Hilton ST., 70 WARD)2-FULL NAME Leashirine H. Ruesey(a) RESIDENCE NO. 26 S Hilton ST., 70 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Ruesey6 DATE OF BIRTH (month, day, and year) Oct 237 AGE Years 41 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.Y. City10 NAME OF FATHER Anthony McEvey11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Elizabeth Long13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14

Informant John L. Ruesey
(Address) 26 S Hilton St

15

Filed Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 19 1922, to Aug 19 1922, that I last saw him alive on Aug 19 1922, and that death occurred, on the date stated above, at 12 a. m.
The CAUSE OF DEATH* was as follows:Ac. Cardiac Delection
(duration) yrs. mos. ds.CONTRIBUTORY (Secondary) Myocarditis(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Was there an autopsy? NoWhat test confirmed diagnosis? Physical Exam
(Signed) Edw. J. Felt, M. D.(Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL New CentralDATE OF BURIAL Aug 24 192220 UNDERTAKER John CookADDRESS 10 S M

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66933

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

443 N. Lakewood

ST.:

6

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helen Wirth

(a) RESIDENCE. NO.

443 N. Lakewood

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 10 mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jos. J. Wirth

6 DATE OF BIRTH (month, day, and year)

Oct 28/68

7 AGE Years Months Days

60

10

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Jacob Santer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ger.

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Jos. J. Wirth 443 N. Lakewood

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-17th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 14th, 1922, to Aug 17th, 1922.that I last saw her alive on Aug 17th, 1922.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Spontaneous physical tuberculosis

(Signed)

M. D.

19 (Address)

118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Carmel

Aug 21 1922

20 UNDERTAKER

ADDRESS

Jos. J. Wirth 156 N. Luzerne Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66934

D 66934

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE NO. 1513 Union Ave ST. 13 WARD

2-FULL NAME

Hester M. Cook

(a) RESIDENCE NO. 1513 Union Ave. ST. 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 8 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 8 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Hubert M. Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Leah P. Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

PARENTS

14 Informant

(Address)

Hubert M. Cook

15

Robert P. Harrison,

20 1922

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1922, to Aug. 18, 1922, that I last saw her alive on Aug. 18, 1922, and that death occurred, on the date stated above, at 3:55 p.m.

The CAUSE OF DEATH* was as follows:

Mammary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 14

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. W. H. Hoff, M. D.

Address) 2020 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Shrewsbury, Pa.

20 UNDERTAKER

Horace A. Burge

DATE OF BURIAL

Aug. 21, 1922

ADDRESS

3631 Fall Rd.

D 66935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Henson. (C).1213 Division St.

(Residence in Baltimore: No. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, (Write the word.) Married6-DATE OF BIRTH, Do not know. 1. (Month) (Day) (Year)7-AGE, 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 0409-BIRTHPLACE, (State or Country), Baltimore Md.10-NAME OF FATHER, James Henson. (C).11-BIRTHPLACE OF FATHER, (State or Country), Maryland.12-MAIDEN NAME OF MOTHER, Sarah Willet. (C).13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Henson. (C). (wife).(Address) 1213 Division St.

15-

Filed Robert P. Harrison, Registrar.

0 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 16th. 1922. 192... (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Pelvis. shock.
Accidentally run over by auto truck.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) W. H. Harrison (Coroner.) Aug. 20, 1922 (Address) 1217 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted, if not at place of death?
Barre & Light Sts. Aug. 16th. 1922

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. AuburnAug. 20, 1922

20-UNDERTAKER

ADDRESS 142John H. FoadwinW. H. Harrison

Is very important. See instructions on back of certificate.

D 66936
15-10-21 P.M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

IN 66936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Samuel Gent

(a) RESIDENCE NO.

274 Regis Ave

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteMarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

6 DATE OF BIRTH (month, day, and year)

July 24 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

7325

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

?

10 NAME OF FATHER

John R. Gent

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER

Ann Wilderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ba.

14

Informant JOHNS HOPKINS HOSPITAL
(Address)

15

Robert P. Harrison

, 19

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 20, 1922, to Aug 18, 1922.that I last saw him alive on Aug 18, 1922and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

carcinoma of prostate.

CONTRIBUTORY (Secondary)

(duration)

3 yrs.1 mos.

ds.

(duration)

yrs.

7 mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? lab & autopsy

(Signed)

J. L. Hough, M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Westmont Hill CemeteryAug 21 1922

20 UNDERTAKER

ADDRESS 1000George G. SmithBayviewExact statement of OCGCPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

20 1922

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 1444 Towson) ST. 24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2 FULL NAME John. F. Heil
(Residence in Baltimore: No. 1444 Towson Dr St. _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH January 15, 1922
(Month) (Day) (Year)

7 AGE 7 yrs. 4 mos. 4 ds. If LESS than 1 day, _____ hrs. or _____ min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Frank Heil

11 BIRTHPLACE OF FATHER (State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER Theresa Seriatz

13 BIRTHPLACE OF MOTHER (State or country) Austria Hungary

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Heil

(Address) 1444 Towson Dr

15 Robert P. Harrison,

1922 191 Burial Permit Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Aug 19, 1922
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 17, 1922 to Aug 19, 1922
that I saw him alive on Aug 18, 1922
and that death occurred, on the date stated above, at 10:30 a.m.
The CAUSE OF DEATH* was as follows:

Bacterial Pneumonia
(Duration) _____ yrs. _____ mos. 1 ds.

Contributory with deep cavity
(SECONDARY) (Duration) _____ yrs. _____ mos. 2 ds.

(Signed) Thos F. Stevens M. D.
Aug 19, 1922 (Address) 2878 Stanford Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Holy Cross Cem. A.C. Co. DATE OF BURIAL Aug 21, 1922

20 UNDERTAKER John J. Fahey & Sons ADDRESS 38 Light St

D 66938

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66938

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 23 South Baltimore General Hospital Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert H. Schaumburg, Jr.

8 --- 5 --- 10.

(Residence in Baltimore: No. 1605 S. Charles St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH, March 8th, 1914. (Month) (Day) (Year)

7-AGE, 8 yrs. 5 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country),

Baltimore Md.

PARENTS.

10-NAME OF FATHER, Robert H. Schaumburg Sr.

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Marguerite Williams.

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert H. Schaumburg Sr.

(Address) 1605 S. Charles St. (father)

15-

Robert P. Harrison,

201922

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall from a motorcycle.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

SP. (Signed) Otto M. Pennington M. D. (Coroner) Aug. 19, 1922. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Pennington Ave. & Church St. Curtis Bay August 18th, 1922.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western Cemetery Aug 20th 1922

20-INTERVIEWER

ADDRESS

C. New McCalister

HEALTH DEPARTMENT—CITY OF BALTIMORE

66939

D 66939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Riverside Ave ST. 24th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dorothy Schultz(a) RESIDENCE. NO. 1119 Riverside Ave ST. 24th WARD.(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 0 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 12, 19227 AGE Years Months Days If LESS than 1 day, hrs. or min.
0 1 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland10 NAME OF FATHER Edward Elmer Schultz11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.12 MAIDEN NAME OF MOTHER Mary Magdalen Graves13 BIRTHPLACE OF MOTHER (city or town) St Mary's Co.,
(State or country) Maryland14 Informant Mother Mary Graves Schultz
(Address) 1119 Riverside Ave.15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 19, 192217 I HEREBY CERTIFY, That I attended deceased from July 12, 1922, to August 19, 1922, that I last saw her alive on August 19, 1922, and that death occurred, on the date stated above, at 3:00 P. M.

The CAUSE OF DEATH* was as follows:

InanitionCONTRIBUTORY (Secondary) Gastro enteritis
(duration) 0 yrs. 1 mos. 0 ds.
(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.
, 19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross Aug 21 1922

20 UNDERTAKER ADDRESS

Margaret G. Flynn 1420 Light

01922

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Hubbard ST. 24 WARD)REGISTERED NO. 131

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicklaus F. Feimer(a) RESIDENCE. NO. 1404 Hubbard ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) single5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Cher)6 DATE OF BIRTH (month, day, and year) Sept. 18, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland10 NAME OF FATHER Peter Feimer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Winston-Salem12 MAIDEN NAME OF MOTHER Julia Hill

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Winston-Salem

14

Informant

(Address) 1404 Hubbard St.

15

Robert F. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 19 22

17

I HEREBY CERTIFY, That I attended deceased from August 8, 19 22, to August 18, 19 22.that I last saw him alive on August 18, 19 22and that death occurred, on the date stated above, at 4:15 p. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 10 ds.(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) G. S. Marr, M. D.

8.18.1922 (Address)

801 V. Eaton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cem.Aug 21 19 22

20 UNDERTAKER

ADDRESS

Margaret G. Flynn 1422 Light St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

201922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—Accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Probably tuberculous

D 66941

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66941

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

Md. Gen. Hosp.

St.

Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William B. Morris

(Residence in Baltimore: No.

508 Beaumont Ave.

St.; yrs.

42

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, white
5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH

July 26, 1880
(Month) (Day) (Year)

7-AGE

42 yrs., 23 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

Builders

9-BIRTHPLACE,

(State or Country)

Balts. Md.

10-NAME OF FATHER,

Isaac Morris

11-BIRTHPLACE OF FATHER,

Md.

12-MAIDEN NAME OF MOTHER,

Mary Spang

13-BIRTHPLACE OF MOTHER,

Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. Morris Jr.

(Address)

508 Beaumont Ave.

15.

Filed

AUG 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 18, 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

gun - shot wound
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. I. Hennessy, M. D.
(Coroner.)

August 19, 1922 (Address) 2802 Edmonson Ave.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Woodlawn Cemetery

Aug 21, 1922

20-UNDERTAKER,

ADDRESS

Jno. Spence

1325 4th Avenue

157485 HEALTH DEPARTMENT—CITY OF BALTIMORE D 66942

D 66942

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thelma Wilkes

(a) RESIDENCE NO.

117 West St., City

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb. 20, 19227 AGE Years Months Days If LESS than 1 day, hrs. or min.
5 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Maryland

10 NAME OF FATHER

Lloyd Lewis11 BIRTHPLACE OF FATHER (city or town)
(State or country)North Carolina

12 MAIDEN NAME OF MOTHER

Jane Wilkes13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Virginia

14

Informant
(Address)JOHNS HOPKINS HOSPITAL

15

AUG 21 1922ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17, 192217 I HEREBY CERTIFY, That I attended deceased from
August 14, 1922, to August 17, 1922,
that I last saw her alive on August 17, 1922,
and that death occurred, on the date signed above, at 1:45 P. M.The CAUSE OF DEATH* was as follows:
Pneumonia SecondaryCONTRIBUTORY (Secondary) Stasis media
Syphilis, congenital
(duration) yrs. mos. 2 ds.
(duration) yrs. mos. 5 ds.18 Where was disease contracted
if not at place of death? HomeDid an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? TB Ray(Signed) T B Ray, M. D., 19 (Address) Johns Hop Kes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Marys CT

20 UNDERTAKER

L. E. Brown & Son

DATE OF BURIAL

Aug 19 1922

ADDRESS

St. Marys

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66943

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John W. Clark

(a) RESIDENCE. NO.

704 Sarah Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofClara Clark

6 DATE OF BIRTH (month, day, and year)

Sept 5, 1897

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.241112

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundryman 041

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

James Clark

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant
(Address)Robert H. Krauter

15

Filed

19

ROBERT H. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August-17 1922

17

I HEREBY CERTIFY, That I attended deceased from

June-9-1922, to August-17, 1922.that I last saw him alive on August-17, 1922.and that death occurred, on the date stated above, at 3:17 p.m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion, acute
Tonsillitis and Pericarditis(duration) yrs. mos. 6 ds.CONTRIBUTORY
(Secondary)Toxic absorption from pyorrhea
and tonsillar follicles (duration) yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death?

noDid an operation precede death? no

Date of

Was there an autopsy? noWhat test confirmed diagnosis? General physical examination(Signed) William H. Schwarz M. D.17. 1922 (Address) Maryland Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt auburnaug 26 1922

20 UNDERTAKER

ADDRESS

W B Cross 1405 Maryland

TION is very important. See instructions on back of certificates.

AUG 21 1922

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 66944

1-PLACE OF DEATH D 66944 CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. 556 W. Preston St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Ira Crofton

(Residence in Baltimore: No. 556 W. Preston St. 22 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Colored

5-Single, Married, Widowed, or Divorced (Write the word.)

Single

6-DATE OF BIRTH

at March 1, 1922

7-AGE

22 yrs. 5 mos. 17 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Farmer OH

9-BIRTHPLACE (State or Country)

Balto, Md.

10-NAME OF FATHER

Thos. Crofton

11-BIRTHPLACE OF FATHER (State or Country)

Va.

12-MAIDEN NAME OF MOTHER

Susie Bratman

13-BIRTHPLACE OF MOTHER (State or Country)

Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Dallie Webb

(Address)

556 W. Preston St.

AUG 21 1922

ROBERT R. KRAUTER

Filed 1922

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug. 18, 1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Pul. Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) 1 yrs. mos. ds.

(Signed) J. T. Hennessey, M. D.

(Coroner) Aug. 18, 1922 (Address) 2812 Edmondson Ave

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

UNIVERSITY OF MARYLAND 8/19/22

20-UNDERTAKER ADDRESS

Cecil's Mortuary

For Wm. Z. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Eka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66945 CERTIFICATE OF DEATH.

161-001
D 66945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST.; WARD)

2-FULL NAME

(a) RESIDENCE. No. ST.; WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

6 1/2 months in Utero

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

File AUG 21 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, that I attended the deceased from August 18 to August 19, 1922

that I last saw him alive on August 18, 1922

and that death occurred, on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Con genital debility
Premature Birth
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) J. H. H. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **D 66946**CITY OF BALTIMORE: (No. *University Hospital* ST. *161* WARD)2-FULL NAME *Baby - boy - Harrison*(a) RESIDENCE NO. *Manistowille, Ind.* ST. _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

21

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 26, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

University Hospital

10 NAME OF FATHER

Harry Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Glenwood Maryland

12 MAIDEN NAME OF MOTHER

Edna Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Manistowille Maryland

14

Informant (Address)

ROBERT R. JOHNS

15

Filed

*AUG 21 1922**Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 16 1922*

17

I HEREBY CERTIFY, That I attended deceased from *July 26, 1922*, to *August 16, 1922*, that I last saw him alive on *August 16, 1922*, and that death occurred, on the date stated above, at *11-30 A. m.*

The CAUSE OF DEATH* was as follows:

Prematurity - (Caesarian Section performed upon mother because of Eclampsia)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No.*

What test confirmed diagnosis?

(Signed)

Wm. J. Fulton, M. D.

, 19

(Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

HOPKINS HOSPITAL

20 UNDERTAKER

Funeral Home

DATE OF BURIAL

AUG 15 1922

ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

72

D 66947

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66947

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square West 20* ST. WARD)2-FULL NAME *Howard Gordon Walters*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *2231 Melrose Ave* ST.

WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred *1* yrs. *6* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 7, 1916*7 AGE Years *5* Months *9* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *N.Y.* (State or country)10 NAME OF FATHER *John Lee Walters*11 BIRTHPLACE OF FATHER (city or town) *Caroline* (State or country)12 MAIDEN NAME OF MOTHER *Jennie G. Mullen*13 BIRTHPLACE OF MOTHER (city or town) *N.Y.* (State or country)14 Informant *John Lee Walters* (Address) *2231 Wickham Ave*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 19 1922*17 I HEREBY CERTIFY, That I attended deceased from *Aug 17 1922* to *Aug 19 1922* that I last saw him alive on *Aug 19 1922*and that death occurred, on the date stated above, at *1230 a* m.

The CAUSE OF DEATH* was as follows:

Tetanus(duration) yrs. mos. *2* ds.CONTRIBUTORY *Infectious Tox* (Secondary) (duration) yrs. mos. *10* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Symptoms signs*(Signed) *Walter A. Cox* M. D.19 (Address) *541 Fulton Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER *Harry H. Witzke* ADDRESS *1831 W. Lomb*

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 21 1922

ROBERT R. KRAUTER

Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66948

CERTIFICATE OF DEATH.

D 66948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

917 Rodgers Av. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elise Sophie Alice Eisenbrandt

(a) RESIDENCE. No.

917 Rodgers Av. ST. 27 WARD. Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

W. Albert Eisenbrandt

6 DATE OF BIRTH (month, day, and year)

December-20-1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

8

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Alex. H. Schulz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

not known Germany

12 MAIDEN NAME OF MOTHER

Anna Hauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

not known Germany

14

Informant (Address)

W. Q. Eisenbrandt - (husband)
917 Rodgers Av. - Ct.

15

AUG 21 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 20, 1922, to Aug 20, 1922,

that I last saw him alive on Aug 15, 1922,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Endo + Myocarditis

(duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Angina Pectoris acute dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

City

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

long observation

(Signed)

Joseph J. Schickel M. D.

(Address)

1516 Madison Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Cemetery

Aug-22-1922

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

1516 Madison Av.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66949

CERTIFICATE OF DEATH.

D 66949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Mulliken ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1304 Mulliken St.; 22 yrs., 22 mos., 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)
unmarried

6-DATE OF BIRTH,

unknown, 1

(Month) (Day) (Year)

7-AGE,

Approx - 56 yrs

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

at home

(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9-BIRTHPLACE,
(State or Country).

S.C.

10-NAME OF FATHER,

Jackson Miller

11-BIRTHPLACE OF FATHER
(State or Country).

S.C.

12-MAIDEN NAME OF MOTHER

Emmaline Miller

13-BIRTHPLACE OF MOTHER
(State or Country).

S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Blanche Crowe

(Address).....

1304 Mulliken St.

15-

AUG 21 1922

ROBERT H. KRAUTER,

Burlal. Permit. Clerk,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

8, 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

8/15 1922, to 8/18 1922,

that I saw her alive on 8/18 1922,

and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

Cerebral Hemorrhage

(Duration).....yrs.....mos.....ds.

(Signed).....R. J. Young M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Fellows Cemetery

DATE OF BURIAL,

Aug 21, 1922

20-UNDERTAKER

Mr. Robert A. Elliott & Son

ADDRESS

1726

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 66950****D 66950**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *South Balto General Hospital*REGISTERED NO. *119-002*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *1213 Light St.* ST. *13* WARD)2-FULL NAME *Baby Howard M. Kay*(a) RESIDENCE NO. *2854 Spring Hill* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *3* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 27/1919*7 AGE Years *2* Months *8* Days *17* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *2854 Spring Hill Ave* (State or country) *are*10 NAME OF FATHER *Howard W. McLeary*11 BIRTHPLACE OF FATHER (city or town) *Seattle Washington* (State or country)12 MAIDEN NAME OF MOTHER *Bertha Aullman*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md* (State or country)14 Informant *Howard W. McLeary* (Address) *2854 Spring Hill Ave*15 *AUG 21 1922* *ROBERT R. KRAUTER,* Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 19 1922*17 I HEREBY CERTIFY, That I attended deceased from *August 18 1922* to *August 19 1922*; that I last saw him alive on *August 19 1922*; and that death occurred, on the date stated above, at *1:40 P. m.*

The CAUSE OF DEATH* was as follows:

*Acute Cardiac Dilatation*CONTRIBUTORY (Secondary) *Interruption of bowel* (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted *2854 Spring Hill Ave* if not at place of death?Did an operation precede death? *Yes* Date of *August 19/22*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John G. O'Connor* M. D.(Address) *South Balto Gen Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*St. Vincent's Cemetery*20 UNDERTAKER *Rushmore**J. F. Eline*

DATE OF BURIAL

Aug 21 1922

ADDRESS

Rushmore

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66951

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66951

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1937 Vine St ST. 70 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1937 Vine St ST. _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 30 yrs. mos. ds.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wife

6 DATE OF BIRTH (month, day, and year) Aug 15, 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

England

10 NAME OF FATHER

Edw Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Joseph Kelly
2437 Vine St

15

File AUG 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 19, 1922, to Aug 20, 1922

that I last saw her alive on Aug 19, 1922

and that death occurred, on the date stated above, at 12³⁰ m.

The CAUSE OF DEATH is as follows:

Chronic Endocarditis
Arthritis deformans

(duration) 4 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

No Date of

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw A. Coakley, M. D.

Address 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

Aug 22, 19

20 UNDERTAKER

ADDRESS

Wm. J. Fields 1200 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66952

CERTIFICATE OF DEATH.

129 D 66952

1-PLACE OF DEATH *Municipal Hosp.*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *76* ST., *76* WARD)

2-FULL NAME *Dorothy White*

(a) RESIDENCE NO. *Chronic Hospital—Bay View*

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *48* yrs. *3* mos. *19* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced

(or) WIFE of *Late David P. White*

6 DATE OF BIRTH (month, day, and year) *Apr 29-74*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48 + 3 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Belle*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address) *H. R. Reed*

15

AUG 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 18 1922*

17

I HEREBY CERTIFY, That I attended deceased from

1-2-1922 to *8-18-1922*

that I last saw him alive on *8-18-1922*

and that death occurred, on the date stated above, at *1:35 P. M.*

The CAUSE OF DEATH* was as follows:

Hypertension and Atherosclerosis

CONTRIBUTORY (Secondary) *Chronic nephritis* (duration) *10* yrs. ? mos. ds.

(duration) *2* yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *FM*

What test confirmed diagnosis?

(Signed) *Chas. McNeill* M. D.

8/18, 1922 (Address) *Municipal Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Bachman's Cem.

20 UNDERTAKER

Philip Hernig

DATE OF BURIAL

8/21 1922

ADDRESS

2016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66953

CERTIFICATE OF DEATH.

31 D 66953

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Orleans ST., 6 WARD)

2. FULL NAME

Charles Hager

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

1902 Orleans

ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of Blanche Hager (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14-77

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

3

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Fred. Hestack

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Des. Hager

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Blanche Hager
1402 Orleans St.

15

AUG 21 1922

ROBERT N. KRAUTER,

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1922

17

HEREBY CERTIFY, That I attended deceased from May 8 1922 to Aug 18 1922, that I last saw him alive on Aug 17 1922, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Kern M. D.

(Address) 4134 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Mount Carmel

8/21 1922

20 UNDERTAKER

ADDRESS

Philip Herwig

Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 66954

HEALTH DEPARTMENT—CITY OF BALTIMORE 66954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *110 W 23rd St.*) ST. *17* WARD

2-FULL NAME

(a) RESIDENCE NO. *110 W 23rd St.* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *57* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan 1871*

7 AGE *57* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto* (State or country)

10 NAME OF FATHER *Table Skinner*

11 BIRTHPLACE OF FATHER (city or town) *md* (State or country)

12 MAIDEN NAME OF MOTHER *Mary Rhodes*

13 BIRTHPLACE OF MOTHER (city or town) *md* (State or country)

14 Informant *Essie Edwards* (Address) *110 W 23rd St.*

AUG 21 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 19th 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Aug 17*, 1922, to *Aug 19*, 1922, that I last saw him alive on *Aug 19th*, 1922, and that death occurred, on the date stated above, at *1:20 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction.

(duration) yrs. mos. ds.

CONTRIBUTORY *Caustication & Inactivity* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *no*

Did an operation precede death? *no* Date of *no*

Was there an autopsy? *no*

What test confirmed diagnosis? *Physical Exam.*

(Signed) *Geo. Hall*, M. D.

, 19 (Address) *426 E 23rd St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Int - Auburn DATE OF BURIAL *Aug 21 1922*

20 UNDERTAKER

John H. Tradem ADDRESS *142*

D 66955 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Municipal Hosp* ST. *76* WARD)

2-FULL NAME

William Johnson

(a) RESIDENCE NO.

Municipal Hospital ST. *76* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bookmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Leahurst Co. Ind.

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant (Address)

Hospital Records Municipal Hosp

AUG 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Aug 19 1922 to Aug 19 1922*that I last saw him live on *Aug 19 1922*and that death occurred, on the date stated above, at *3:30 p.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue with metastases(duration) *—* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(duration) *—* yrs. *—* mos. *—* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

*Green Hill Cem**Aug 22 1922**Wm J E Burns & Son**1420 N. E. Ave*

D 66956

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2822 E. McGowan St. Ward 7)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

(Residence in Baltimore: No. 2822 E. McGowan St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced. (Write the word.)6-DATE OF BIRTH, Aug 19, 1922
(Month) (Day) (Year)7-AGE, If LESS than 1 day, yrs., mos., ds. 1 1/2 hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Beth md.10-NAME OF FATHER, Samuel Sabatino11-BIRTHPLACE OF FATHER, (State or Country), Italy12-MAIDEN NAME OF MOTHER, Conietta Guzzetta13-BIRTHPLACE OF MOTHER, (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- AUG 21 1922

Filed 192 21 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 19, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Natural Cause
Myocardial infarction, very
dark, with long
possibly, congested
(Duration) yrs., mos., ds.CONTRIBUTORY (Secondary) Heart(Signed) J. S. Potter M. D.

(Coroner.)

Aug 20 1922 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, suicidal, or homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cath. Cem. 8/21/22, 1922

20-UNDERTAKER, ADDRESS

Geo. J. Ruth 1735 Fairfax Ave.

STATE CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D 66957 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Agnes Hosp-

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 20 WARD)

2-FULL NAME

Winifred C Kennedy

(a) RESIDENCE No.

3328 Frederick Ave.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 24 1889

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

9

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

048

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Winifred O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

(Address)

3328 Frederick Ave.

15

AUG 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8-19-22

17

I HEREBY CERTIFY, That I attended deceased from

4-3-22, 19, to 8-19, 1922.

that I last saw her alive on 8-19-22, 19

and that death occurred, on the date stated above, at 11:10 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis - Mitral Insufficiency - Myocardial Insufficiency - (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac failure (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical

(Signed) Wm. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66958

CERTIFICATE OF DEATH.

D 66958

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 273 Mc Carley ST., 30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 273 Mc Carley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

s.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

AUG 21 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20 19 22

17

I HEREBY CERTIFY, That I attended deceased from

8/19 1922, to 8/20 1922,that I last saw him live on 8/20 1922,and that death occurred, on the date stated above, at 5:15 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia of typhoid
baillus and
enlarged glands of neck(duration) yrs. mos. 2 ds.CONTRIBUTORY
(Secondary)typhoid tonsillar(duration) yrs. mos. 5 ds.18 Where was disease contracted
if not at place of death?273 Mc Carley StDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Dan P. Alagia M. D., 19 (Address) 3326 Franklin Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALLouisa Park Ave

20 UNDERTAKER

Edw. J. Sullivan

DATE OF BURIAL

8/21 1922

ADDRESS

Franklin Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 23 WARD)

2-FULL NAME

Rose Brown

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 918 Peach Alley

ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18867 AGE Years Months Days If LESS than 1 day, hrs. or min. 36 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) Charleston, (State or country) South Carolina10 NAME OF FATHER Wm. Jenkins11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina12 MAIDEN NAME OF MOTHER Agnes Williams13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14

Informant Hospital Records, (Address) Municipal Hospital.

15

Aug 21 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 19 2217 I HEREBY CERTIFY, That I attended deceased from July 27, 19 22, to August 17, 19 22, that I last saw her alive on August 16, 19 22, and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Bilateral Pyo Salpinx
P.T.D.(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Richardson Joyce, M. D.3/17/22 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Pelvic inflammatory
disease. Gonococcus
infection.*

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66960

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital)ST.: 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fredow(a) RESIDENCE. NO. Unknown

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18627 AGE Years Months Days If LESS than 1 day, hrs. or min. 60

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Orderly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant Hospital Records,
(Address) Municipal Hospital

15

AUG 21 1922 ROBERT R. KRAUTER,
Filed RegistrarBurial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 19 2217 I HEREBY CERTIFY, That I attended deceased from April 5, 19 22, to August 16, 19 22, that I last saw him alive on August 16, 19 22, and that death occurred, on the date stated above, at 3:22 P.M.
The CAUSE OF DEATH* was as follows:Acute insufficiencyCONTRIBUTORY (Secondary) Myocardial inf.
(duration) 2 yrs. mos. ds.
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Chas. M. Neil M. D.
8/17/22 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

ADDRESS

AUG 21 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

72

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66961

D 66961

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 6 WARD)2-FULL NAME Laura Groves(a) RESIDENCE NO. 443 N. Robinson St. ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed,
or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of U
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18607 AGE Years Months Days If LESS than
62 -- -- 1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Housework
(b) General nature of industry,
business, or establishment in
which employed (or employer)
(c) Name of employer9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland10 NAME OF FATHER William Groves11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia12 MAIDEN NAME OF MOTHER Frances Dennis 8/19/22 (Address) Municipal Hospital13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia14 Informant Hospital Records,
(Address) Municipal Hospital.15 Filed ROBERT N. KRAUTER, 19 21 Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 19 2217 I HEREBY CERTIFY. That I attended deceased from
July 10, 19 22 to August 19, 19 22.
that I last saw her alive on August 18, 19 22.
and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute peritonitis
(Cause undetermined at autopsy)
(duration) yrs. mos. 10 ds.CONTRIBUTORY Arteriosclerosis
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy
(Signed) Clyde M. Mowbray, M. D.8/19/22 (Address) Municipal Hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVALPrivately buried Aug 22 19 2220 UNDERTAKER Geo W. Fink ADDRESS 1111 N. E. AveExact statement of OCCUPA-
TION is very important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

D 66962

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66962

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Square Hospital* 18) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1241 W Lombard* St.; yrs. *43* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Widow* (Write the word.)6-DATE OF BIRTH, *Feb. 16* 18*85* (Month) (Day) (Year)7-AGE, *63* yrs. *6* mos. *4* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- Packer 086*
-
- (b) General nature of industry, business, or establishment in which employed (or employer).
- Frank Co*

9-BIRTHPLACE, (State or Country).

Carroll Co Md

10-NAME OF FATHER.

George Wagner

11-BIRTHPLACE OF FATHER, (State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Margaret Smith

13-BIRTHPLACE OF MOTHER, (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Biegel*
(Address) *1241 W Lombard*

15-

Robert P. Harrison,

211922

1922

Burial Permit Clerk,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *July Aug. 20* 192*2* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Investigation* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Investigation* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Fractured Ribs, Comp. by falling on open street street car tracks*CONTRIBUTORY (Secondary) *Hypostatic Pneumonia* (Duration) yrs. mos. ds.(Signed) *James M. Benton* M. D. (Coroner.)Aug. 24, 1922. (Address) *701 E. Chase St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents.)

At place of death, *Franklin Square* In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

*Lombard St. near 35*Former or usual residence *1241 W Lombard*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Sorbonne Cemetery Aug. 24, 1922

20-UNDERTAKER, ADDRESS

Wm Cook *502 E North*

D 66963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66963

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *536 Wellesley* St., *70* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *536 Wellesley* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Single* (Write the word.)6-DATE OF BIRTH, *Aug 23*, 192*1* (Month) (Day) (Year)7-AGE, *11* yrs., *27* mos., ds. If LESS than 1 day, hrs., or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *none* (b) General nature of industry, business, or establishment in which employed (or employer), *000*9-BIRTHPLACE, (State or Country), *Balt City*10-NAME OF FATHER, *Robert Weisinger*11-BIRTHPLACE OF FATHER, (State or Country), *Balt City*12-MAIDEN NAME OF MOTHER, *Carie Rittershagen*13-BIRTHPLACE OF MOTHER, (State or Country), *Balt City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Carie Weisinger*(Address) *536 Wellesley St.*

15-

Robert P. Harrison, Registrar.

Filed

1922

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 20*, 192*2* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*, and that said deceased came to *her* death (Inquest, autopsy or inquiry.) on the day stated above.The CAUSE OF DEATH* was as follows: *Neural degeneration*

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) *lack proper nourishment*(Signed) *James M. D.* (Coroner.)*Aug 20*, 192*2* (Address) *700 E. Charles St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL or REMOVAL, *Landon Park* DATE OF BURIAL, *Aug 22*, 192*2*20-UNDERTAKER, *L. W. Dill* ADDRESS *3109**Frank Ave.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66964

D 66964

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 17

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 1922

17

I HEREBY CERTIFY, That I attended deceased from August 11, 1922, to August 21, 1922, that I last saw him alive on August 21, 1922, and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Infectious Intoxication

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isidore J. Furg, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

2-1-1922

Burial Permit Clerk.

JACK KURTZ, 1439 E. Balt

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66965

CERTIFICATE OF DEATH.

88 D 66965

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3036 Windsor Avenue ST., 15 WARD)

REGISTERED NO. _____
 (If death occurred in
 a hospital or institu-
 tion, give its NAME
 instead of street and
 number.)

2-FULL NAME Marie Louise Tiralla

(a) RESIDENCE NO. 3036 Windsor Avenue ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 11 mos. 18 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed,
 or Divorced, (write the word) Single

5a If married, widowed, or divorced
 HUSBAND of
 (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 31, 1902

7 AGE Years Months Days If LESS than
 1 day, hrs. or min.
 19 11 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or
 particular kind of work None(b) General nature of industry,
 business, or establishment in
 which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
 (State or country) Maryland

10 NAME OF FATHER Joseph Tiralla

11 BIRTHPLACE OF FATHER (city or town) Baltimore
 (State or country) Maryland

12 MAIDEN NAME OF MOTHER Marie E. Lucas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
 (State or country) Maryland14 Informant Mrs. Marie E. Tiralla
 (Address) 3036 Windsor Avenue

15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from
 August 25, 1921, to Aug 19, 1922,
 that I last saw him alive on Aug 19, 1922,
 and that death occurred, on the date stated above, at 4:120, m.

The CAUSE OF DEATH* was as follows:

Endocarditis lenta
 (subacute endocarditis)

(duration) yrs. mos. ds.
 CONTRIBUTORY Emboli (cerebral)
 (Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted
 if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture etc.
 (Signed) J. A. Schuler, M. D.

, 19 (Address) 1025 Mad. av.

*State the Disease Causing Death, or in deaths from Violent Causes,
 state (1) Means and Nature of Injury, and (2) whether Accidental,
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
 MOVAL

Loudon Park Cemetery

DATE OF BURIAL

8/22, 1922

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
 TION is very important. See instructions on back of certificates.

21 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66966

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2914 Walbrook av ST. 15 WARD)

2. FULL NAME

Viola Marie Stenz

(a) RESIDENCE NO. 2914 Walbrook av ST. 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Charles W. Stenz

6 DATE OF BIRTH (month, day, and year) Apr 1898

7 AGE

Years 24

Months 4

Days 14

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

10 NAME OF FATHER Chas. Schumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) 2914 Walbrook av

15 Filed 21 1922

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1922 to Aug 19 1922

that I last saw her alive on Aug 19 1922

and that death occurred, on the date stated above, at 12.30 A.M.

The CAUSE OF DEATH* was as follows:

Myocard Stenosis

CONTRIBUTORY (duration) yrs. 6 mos. ds.

Acute Dilatation (Secondary) (duration) yrs. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed) T. J. C. M. M. D.

(Address) 2737 W. North St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

20 UNDER TAKER

DATE OF BURIAL

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66967

CERTIFICATE OF DEATH.

D 66967

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 N. Central ave. ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 1024 N. Central ave ST., 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds.How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Amelia M. Biittner6 DATE OF BIRTH (month, day, and year) June 18th 18647 AGE Years 58 Months 2 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany10 NAME OF FATHER Ferdinand Biittner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany12 MAIDEN NAME OF MOTHER Katherine Rals

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany14 Informant Amelia M. Biittner (Address) 1024 N. Central ave

15

Filed

1922 Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 192217 I HEREBY CERTIFY, That I attended deceased from January 15, 1922, to Aug 20, 1922, that I last saw him alive on Aug. 20, 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

20 UNDERTAKER

George Schilling & Sons

DATE OF BURIAL

Aug 23rd 1922

ADDRESS

1126 Edmonst

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66968

CERTIFICATE OF DEATH.

D 66968

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Fairview Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No. 3501 Fairview Ave ST., 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

~~HUSBAND~~ of Charles Crowley
~~WIFE~~ of6 DATE OF BIRTH (month, day, and year) Aug-15-18527 AGE Years 70 Months — Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

1922

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-19-1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 12, 1922, to Aug 18, 1922,that I last saw him alive on Aug 18, 1922,and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) yrs. mos. 19 ds.

CONTRIBUTORY (Secondary)

Severe (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of +Was there an autopsy? NoWhat test confirmed diagnosis? Smear(Signed) Charles B. Hill M. D., 19 (Address) Wylie St. 15

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

Cathedral Cemetery Aug-22-1922ADDRESS 2236Wm J Hartwell W. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

STATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66969

CERTIFICATE OF DEATH.

113 D 66969

PLACE OF DEATH

CITY OF BALTIMORE (No. 2131 Maryland Ave. ST. 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie Diana Anders.

(Residence in Baltimore: No. 2131 Maryland Ave. St.: yrs., mos. ds.)

3 20

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-SINGLE, Married, Widowed, OR DIVORCED, Write the word Baby

6-DATE OF BIRTH, April 23, 1922
(Month) (Day) (Year)

7-AGE, 3 20 If LESS than 1 day, hrs. or min.?
yrs. mos. ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country), Baltimore Md.

10-NAME OF FATHER, Jesse S. Anders Jr.

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Myrtle Baker

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle Anders

(Address) 2131 Maryland Ave.

15- Robert P. Harrison, Registrar.

1 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 20, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy, or inquiry thereon and from the evidence obtained by said inquest, autopsy, or inquiry, find that said deceased came to death on the day stated above.

18-CAUSE OF DEATH was as follows:
Gastro-Enteritis
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(Duration) yrs. mos. ds.
(Signed) J. M. Harrison D.
(Address) 3632 W. 1st St.

19-STATE THE DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

20-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

21-PLACE OF BURIAL OR REMOVAL, Lorain Cemetery DATE OF BURIAL, Aug 22, 1922

22-UNDERTAKER, Mrs. C. Miller ADDRESS 2384 Jefferson

D 66970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66970

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Md. Gen. Hospital

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hugh Burkett

(a) RESIDENCE. NO.

Old Frederick Rd. Catonsville

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

Katherine Burkett

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

3

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer + merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

not known Md.

10 NAME OF FATHER

Richard Burkett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

not known Md.

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

not known

14

Informant (Address)

Md. General Hospital
Linden Ave. & Madison

15

Filed

Robert P. [unclear]

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8 / 20 / 22

17

I HEREBY CERTIFY, That I attended deceased from

8 / 19 - 12:30 PM 19 22, to 8 / 20 19 22

that I last saw him alive on

8 / 20 19 22

and that death occurred, on the date stated above, at

6:30 A m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage
duration 8 hrs 30 min

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

clinical

(Signed)

J. H. [unclear] M. D.

19

(Address)

May 1st Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Mt

Aug 23 19 22

20 UNDERTAKER

George H. [unclear]

ADDRESS

1630 [unclear]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

66971

CERTIFICATE OF DEATH.

113 66971

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1209 Riverside Ave* ST., *113* WARD)

2-FULL NAME

(a) RESIDENCE NO. *1209 Riverside* ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1* mos.

ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Full

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 20* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 17*, 19 *22*, to *Aug 20*, 19 *22*, that I last saw him alive on *Aug 20*, 19 *22*, and that death occurred, on the date stated above, at *930 a.m.* The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. *15* ds. CONTRIBUTORY *Exhaustion* (Secondary) (duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *The symptoms*

(Signed) *Jas R. O'Brien* M. D.

(Address) *107 E. West St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

21 1922

Burial Permit Clerk.

Holy Cross Cem. Aug 22 1922
Margaret J. Flynn 1422 High St.

66972

HEALTH DEPARTMENT—CITY OF BALTIMORE

66972

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

12 W Hughes

ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Samuel Taylor

(a) RESIDENCE. NO.

12 W. Hughes

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Col

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 11 - 1873

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.
or min.

49

2

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

Laborer

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Md

10 NAME OF FATHER

John Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mamie Hayes

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Md

14

Informant
(Address)Chas Taylor
a.g. co. Glenburne

15

AUG 22 1922

ROBERT A. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/19/1922

17

HEREBY CERTIFY, That I attended deceased from
8/19/1922, to 8/19/1922,
that I last saw him alive on 8/19/1922

and that death occurred, on the date stated above, at 12:10 PM

The CAUSE OF DEATH* was as follows:

Cardio-Renal Disease
Unknown

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Subacute nephritis
acute

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

none

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

8/21/22

(Address)

908 Ashland St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Elliott Branch

8/22 1922

20 UNDERTAKER

ADDRESS

Jas. M. Skinner 1625 E. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)2-FULL NAME Leonard Berger(a) RESIDENCE NO. Unknown

(Usual place of abode)

ST. 76 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18567 AGE Years Months Days If LESS than 1 day, hrs. or min. 66 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair Spinner(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER John Berger11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Christine Correr13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Hospital Records, (Address) Municipal Hospital.15 AUG 22 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 19 2217 I HEREBY CERTIFY, That I attended deceased from August 18, 1922 to August 20, 1922, that I last saw him alive on August 19, 1922, and that death occurred, on the date stated above, at 7:00 A.M. The CAUSE OF DEATH* was as follows:Hepatic Cirrhosis
(portal)(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Merrill M. D.7/21/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Aug 24 1922

20 UNDERTAKER

ADDRESS

Low's Heeman 326 Broadway

Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

66974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14-S. Gilmer ST., 14 WARD)

2-FULL NAME

William Friedlander

(a) RESIDENCE NO.

14-S. Gilmer ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 5 mos. 18 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 4, 1911.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11 — 5 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Jacob Friedlander

11 BIRTHPLACE OF FATHER (city or town)

Russia

(State or country)

12 MAIDEN NAME OF MOTHER

Wiskingy

13 BIRTHPLACE OF MOTHER (city or town)

Russia

(State or country)

14

Informant (Address)

N. B. Bondenky, M. D., 2114 Wilkens Ave.

15

F. D. No. 22 1922ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22, 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 19 22, to Aug. 22, 19 22, that I last saw him alive on Aug. 21, 19 22, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease.CONTRIBUTORY (Secondary) Pulmonary edema (duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathan B. Bondenky, M. D., 19 (Address) 2114 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL

Wash. Rd.Aug. 23, 1922

20 UNDERTAKER

ADDRESS

Faci Lewis, 1439 E. Balt.

Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Exact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

157902
D 66975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003
D 66975

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward Gassaway

(a) RESIDENCE NO.

1331 Scott St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND
(or) WIFE OF

Edward Gassaway

6 DATE OF BIRTH (month, day, and year)

Aug 16, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Edward Gassaway

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ella Vantermeter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

Robert R. Krauter

AUG 22 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 21 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 19, 1922, to Aug 21, 1922.

that I last saw him alive on Aug 21, 1922.

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Congenital absence of rectum & anus.

Birth
(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? yes Date of 8-20-22

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) T. B. Gay M. D.

(Address) Johns Hopl. Clin. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

St. Oliver Cemetery

20 DATE OF BURIAL

Aug 22 1922

21 ADDRESS

Wm. J. Tuckerton N.Y.P.A.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3904 Bonner Road ST. 15 WARD)

2-FULL NAME

Ida E. Foreman

(a) RESIDENCE

(Usual place of abode) No. 3904 Bonner Road

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofEdwin J. Foreman6 DATE OF BIRTH (month, day, and year) Aug. 23/617 AGE Years Months Days If LESS than 1 day, hrs. or min. 61

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Anarundel Co. Md.

10 NAME OF FATHER

John T. Langville

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto.

12 MAIDEN NAME OF MOTHER

Sarah M. Clackey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto.

14

Informant (Address)

Mrs. Katie Cornell
3409 Bonner Road

Filed

Aug 22 1922ROBERT H. KRAUTER

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 - 192217 I HEREBY CERTIFY, That I attended deceased from July 1 - 1921, to Aug 20 - 1922, that I last saw her alive on Aug 19 - 1922, and that death occurred, on the date stated above, at 7 A m.
The CAUSE OF DEATH* was as follows:SepsisCONTRIBUTORY (Secondary) Paralytic (duration) 1 yrs. mos. ds.
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. H. H. Hays, M. D.
, 19 (Address) 3409 Bonner Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Int. Olivet Cem. Aug. 23 1922

20 UNDERTAKER

For. J. Hen 156 A. Luzerne ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Had paralysis 2 yrs
ago in l. leg since
had l. leg sore which
became septic.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66977

CERTIFICATE OF DEATH.

HFD 66977

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 E. Fayette ST., 6 WARD)

2-FULL NAME

Joseph N. Griffin

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2025 E. Fayette ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

Widowed
(or) Wife ofKatie S. Griffin

6 DATE OF BIRTH (month, day, and year)

July 12-56

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.6617

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Employed at

(h) General nature of industry, business, or establishment in which employed (or employer)

Mutual

(c) Name of employer

Chemical Works

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Jos. Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD.

14

Informant
(Address)Katie S. Griffin
2025 E. Fayette

15

Filed

AUG 22 1922ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/19 1922

17

I HEREBY CERTIFY, That I attended deceased from
April 3, 1922 to Aug 19, 1922that I last saw him alive on Aug 19, 1922and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? yes Date of 2 years ago

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Connel, M. D.(Address) 418 E. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALBalto Cem.

DATE OF BURIAL

8/22 1922

20 UNDERTAKER

Philip Henry

ADDRESS

2012
Delaware

Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 66978

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. Ellwood St. WARD 6)2-FULL NAME Evelyn C. Harryman(a) RESIDENCE NO. 203 N. Ellwood St. WARD 6

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 1 - 077 AGE Years 14 Months 10 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER Harry P. Harryman11 BIRTHPLACE OF FATHER (city or town) (State or country) Md12 MAIDEN NAME OF MOTHER Augusta Schroeder13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.14 Informant Augusta Harryman (Address) 203 N. Ellwood15 AUG 22 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19 192217 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1922, to Aug. 19, 1922, that I last saw her alive on Aug 19, 1922, and that death occurred, on the date stated above, at 5:30 p.m.The CAUSE OF DEATH* was as follows:
Chronic Valvular Endocarditis
Acute EndocarditisCONTRIBUTORY Secondary Anemia (Secondary) (duration) About 5 mos. 2 ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None (Signed) G. Carroll Lockard, M. D.(Address) 46 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Balto Cem. DATE OF BURIAL 8/22 192220 UNDERTAKER Philip Herwig ADDRESS 2916Orleans

Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1 WARD)2-FULL NAME Albert Gibson(a) RESIDENCE NO. 445 S Robinson ST. 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mary Gibson6 DATE OF BIRTH (month, day, and year) Mar 27 - 18587 AGE Years 64 Months -3 Days -17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Elyse Poyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address)15 Filed Aug 22 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 192217 I HEREBY CERTIFY, That I attended deceased from Aug 11 - 1922, to Aug 20 1922, that I last saw him alive on Aug 20, 1922, and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia, following operation for hemorrhoidsAug. 9, 1922 (duration) 0 yrs. 0 mos. 11 ds.CONTRIBUTORY Hemorrhoids, tuberculosis? (Secondary)(duration) 15 yrs. mos. ds.18 Where was disease contracted if not at place of death? Johns Hopkins HospitalDid an operation precede death? Yes Date of Aug. 10, 1922Was there an autopsy? YesWhat test confirmed diagnosis? Post mortem(Signed) R. S. Lyman, M. D.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Trinity CemeteryAug 23 1922

20 UNDERTAKER

ADDRESS

John Reerich2088 Orleans

Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. *As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*; and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Suspicious of
pulmonary tuberculosis*

HEALTH DEPARTMENT—CITY OF BALTIMORE

66980

D 66980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Julia A. Rumpf.

6 DATE OF BIRTH (month, day, and year)

March 20-1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

Stationary Engineer

(c) Name of employer

Continental Trust Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Jacob A. Rumpf.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Julia A. Rumpf.
118 S. Clinton St.

15

Filed

AUG 22 1922

J. E. Kehm

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from August 8, 1922, to August 20, 1922,

that I last saw him alive on August 10, 1922,

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

CONTRIBUTORY (Secondary) Acute Nephritis

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Aug 19 1922

Was there an autopsy? No

What test confirmed diagnosis? Clin. city

(Signed) James Hubert Westerman, M. D.

19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Am.

20 UNDERTAKER

Lilly & Zieher

DATE OF BURIAL

Aug. 22 1922

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 66981

HEALTH DEPARTMENT—CITY OF BALTIMORE

88 D 66981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 750 VineST. 4 WARD

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mamie Travers(Residence in Baltimore: No. 750 Vine

St. _____ yrs. _____ mos. _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE Blk5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Mar, 1882

(Month)

(Day)

(Year)

7-AGE, 40 yrs. 5 mos. _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work Landress

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9-BIRTHPLACE, (State or Country), Balto10-NAME OF FATHER, John Travers11-BIRTHPLACE OF FATHER (State or Country), Balto12-MAIDEN NAME OF MOTHER Married Unknown

13-BIRTHPLACE OF MOTHER (State or Country), _____

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Loma Hawkins(Address) 625 Mosher St

15-

AUG 22 1922

ROBERT R. KRAUTER,

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 20, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 11, 1922, to Aug 20, 1922,that I saw her alive on Aug 19, 1920,and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

acute Myocarditis(Duration) _____ yrs. _____ mos. 2 ds.CONTRIBUTORY (Secondary) Gastroenteritis(Duration) _____ yrs. _____ mos. 9 ds.(Signed) Gustav W. Plummer M. D._____, 1922 (Address) 656 N. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL, St. Auburn etDATE OF BURIAL, Aug 23, 192220-UNDERTAKER J. E. Brown & SonADDRESS 108 W. Montz

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66982

HEALTH DEPARTMENT-CITY OF BALTIMORE

66982

CERTIFICATE OF DEATH

74-001

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 942 N Howard St.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Fannie Brown

Residence in Baltimore: No. 942 N Howard

St. 15 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6. DATE OF BIRTH Unknown, 8 21 (Month) (Day) (Year)

7. AGE 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8. OCCUPATION (a) Trade, profession, or particular kind of work Cook 021 (b) General nature of industry, business, or establishment in which employed (or employer) in Prichard family

9. BIRTHPLACE (State or country) Mathews Co. Va

10. NAME OF FATHER Phillip Cook

11. BIRTHPLACE OF FATHER (State or country) Va

12. MOTHER'S NAME OF MOTHER Mary F Jackson

13. BIRTHPLACE OF MOTHER (State or country) Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Harry Brown

(Address)

942 N Howard

15

AUG 22 1922

191 ROBERT R. KRAUTER

REGISTRAR

Burial Permit 446

16. DATE OF DEATH

8 18, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14, 1922 to Aug 18, 1922 that I saw her alive on Aug 17, 1922 and that death occurred on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Apoplexy following Cerebral hemorrhage

(Duration) yrs. mos. 4 ds

Contributory (SECONDARY) Arterio Sclerosis

(Duration) yrs. mos. ds

(Signed) J. H. Hankins M. D. Aug 24, 1922 (Address) 1202 S Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER

ADDRESS

St. Anthony's Church Aug 22, 1922 Paul Chesley, W. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66983

90 D 66983

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1055 W Lexington ST., 18 WARD)2-FULL NAME William H. Downes(a) RESIDENCE NO. 1055 W Lexington ST., 18 WARD
(Usual place of abode)Length of residence in city or town where death occurred Unknown yrs. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed or divorced HUSBAND of (or) WIFE of Margaret Downes6 DATE OF BIRTH (month, day, and year) March 18657 AGE 57 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

AUG 22 1922

ROBERT W. KRAUTER,

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19/192217 I HEREBY CERTIFY, That I attended deceased from May 30, 1922 to Aug 19, 1922, that I last saw him alive on Aug 19, 1922, and that death occurred, on the date stated above, at 2:30 p. m. The CAUSE OF DEATH* was as follows:Chronic Cardiac Valvulitis(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W. F. Koville M. D.8/22/1922 (Address) 119 N Carrollton Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVEMENT

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 66984 45 D 66984

1-PLACE OF DEATH *Even Neilson*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *University Hospital* ST. *22* WARD)2-FULL NAME *Even Neilson*(a) RESIDENCE NO. *322 N. Paer St.* ST. *22* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *19* yrs. — mos. — ds. How long in U. S., if of foreign birth? *19* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>male</i>	4 COLOR OR RACE <i>white</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Single</i>
----------------------	---------------------------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *1860*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<i>62</i>	<i>—</i>	<i>—</i>	<i>—</i>	<i>—</i>

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Sweden*10 NAME OF FATHER *Nils Neilson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Sweden*12 MAIDEN NAME OF MOTHER *Christina Neilson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Sweden*

PARENTS

14 Informant (Address) *Hospital Records*15 *AUG 22 1922*ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8/16* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *8/16* 19 *22*, to *8/16* 19 *22*that I last saw him alive on *8/16/22* 19 *—*, and that death occurred, on the date stated above, at *4:20 P.M.*

The CAUSE OF DEATH* was as follows:

Surgeical Shock

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Dr. J. J. Murphy*19 (Address) *University Hospital*

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Physicians should state EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT--CITY OF BALTIMORE
D 66985 131 66985
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST., *8* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Jennie King*

(a) RESIDENCE NO. *1824 N. Chapel* ST., _____ WARD *H*
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred *Life* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of *Late David King* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 3, 1881*

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min. *40*

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *Housemaid*
(b) General nature of industry, business, or establishment in which employed (or employer) *070*
(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)

10 NAME OF FATHER *John Holshue*

11 BIRTHPLACE OF FATHER (city or town) *Russia* (State or country)

12 MAIDEN NAME OF MOTHER *Catherine King*

13 BIRTHPLACE OF MOTHER (city or town) *Russia* (State or country)

14 Informant *Margaret Holshue* (Address) *1824 N. Chapel St.*

15 Filed *Robert P. Harrison,* Registrar

22-1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 21 1922*

17 I HEREBY CERTIFY, That I attended deceased from *July 29, 1922*, to *Aug 21, 1922*, that I last saw her alive on *Aug 21, 1922*, and that death occurred, on the date stated above, at *10 P. M.*

The CAUSE OF DEATH* was as follows:
Salpingitis & Ovarian Cyst with adhesions about tube. (not gonorrheal) 5 yrs. _____ mos. _____ ds.

CONTRIBUTORY *Lobar Pneumonia* (Secondary) (duration) _____ yrs. _____ mos. *7* ds.

18 Where was disease contracted if not at place of death? *at home*

Did an operation precede death? *Yes* Date of *July 31-1922*

Was there an autopsy? *No*

What test confirmed diagnosis? *Operation*

(Signed) *F. X. Kennedy*, M. D.

, 19 (Address) *Mercy Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Cemetery *Aug 24 1922*

20 UNDERTAKER ADDRESS

George F. Ruth *1735 Hayford* *201*

D 66987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129th D 66987

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Agnes Hospital* ST., *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Edward Murphy*(a) RESIDENCE NO. *1317 Scott St.* ST., *11* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *5 yrs.* mos. *0* ds.How long in U. S., if of foreign birth? yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Hattie Murphy*6 DATE OF BIRTH (month, day, and year) *Jan 30 1875*

7 AGE

Years

Months

Days

If LESS than
1 day,hrs.
or min.*47 yrs.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Ind.*10 NAME OF FATHER *William P. Murphy*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balto Md*12 MAIDEN NAME OF MOTHER *Mary A Smith*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto Md*

14

Informant
(Address)*Hattie Murphy*
1317 Scott

15

Filed AUG 22 1922

J. E. [Signature]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8-22* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

8-17-1922, 19*22*, to *8-22-1922*, 19*22*.that I last saw him alive on *8-22-1922*, 19*22*.and that death occurred, on the date stated above, at *3:05 a. m.*

The CAUSE OF DEATH* was as follows:

Chn. Nephritis
Chn. Myocarditis(duration) yrs. *0* mos. *0* ds.CONTRIBUTORY
(Secondary)(duration) yrs. *0* mos. *3* ds.18 Where was disease contracted
if not at place of death? *Home*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic*(Signed) *W. E. Caldwell*, M. D., 19 *22* (Address) *812 [Address]*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Cathedral

DATE OF BURIAL

Aug 25 1922

20 UNDERTAKER

William Cook

ADDRESS

502 E. [Address]

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

622

HEALTH DEPARTMENT—CITY OF BALTIMORE

66988

D 66988

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD.

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Louise Olive

6 DATE OF BIRTH (month, day, and year)

May 20-1854

7 AGE

69

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

John R. Olive, Jr.

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

Augustus Olive

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Catherine Deits

13 BIRTHPLACE OF MOTHER (city or town)

Maryland

(State or country)

14

Informant
(Address)John R. Olive, Jr.
2704 Brighton St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug - 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

August 19, 1922, to Aug 22, 1922,

that I last saw him alive on August 22, 1922,

and that death occurred, on the date stated above, at 1:38 A.M.

The CAUSE OF DEATH* was as follows:

Perforation of intestine

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

6 ds.

18 Where was disease contracted
if not at place of death?

402 W 37th St (?)

Did an operation precede death?

Yes Date of Aug 19-1922

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

Anthony V. Buchners, M. D.

19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount

Aug 25 1922

20 UNDERTAKER

William Cook

ADDRESS

502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG

22 1922

Burial Permit Clerk

Jan. 1670

Spec. - 6-9-19 - H. P. Co. - 1000 Bks.

HEALTH DEPARTMENT - CITY OF BALTIMORE

66989

D 66989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Balto-egg, east Throat Hoop.* ST.: *41* WARD)

2-FULL NAME

George L. Baurenschuh

(a) RESIDENCE

No. *541 N. Lakewood Ave.* ST.: *41* WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) *Wife* of *Mrs. Hilda Baurenschuh*

6 DATE OF BIRTH (month, day, and year) *Jan - 15 - 1901*

7 AGE Years *21* Months *7* Days *6* If LESS than 1 day, hrs. *0* or min. *0*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *clerk*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto.* (State or country)

10 NAME OF FATHER *Andrew Baurenschuh*

11 BIRTHPLACE OF FATHER (city or town) *Balto* (State or country) *MD.*

12 MAIDEN NAME OF MOTHER *Bertha Baurenschuh*

13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country) *MD.*

14 Informant *Father* (Address)

15 Filed *Aug 22 1922* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8-21-22*

17 I HEREBY CERTIFY, That I attended deceased from *8-4-22*, to *8-21-22*, 19 *22*

that I last saw him alive on *8-4-22*

and that death occurred, on the date stated above, at *3.30 p.m.*

The CAUSE OF DEATH* was as follows:

Streptococcus Hemolyticus Septicaemia. (duration) yrs. mos. *21* ds.

CONTRIBUTORY *Acute Mastoiditis and lateral thrombosis* (duration) yrs. mos. *28* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *8-5-22*

Was there an autopsy? *No*

What test confirmed diagnosis? *Operation*

(Signed) *J. A. Holden* M. D.

, 19 (Address) *625 W. Franklin St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1), Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Parkwood Cemetery *Aug 24 1922*

20 UNDERTAKER ADDRESS

William Cook *502 E North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Probable cause
intestinal obstruction
No further history

(Pearl M. Gliss)
HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 66990

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 15 WARD)

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

Female White

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

William F. Gliss

6 DATE OF BIRTH (month, day, and year)

May 10, 1878

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

44

3

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

House Work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Va

10 NAME OF FATHER

Thorough Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Lillian M. Burton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Va.

14

Informant
(Address)

William F. Gliss

2112 S. Smallwood

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug - 21 1922

17 I HEREBY CERTIFY, That I attended deceased from
July - 29 - 1922, to Aug - 21 - 1922.
that I last saw her alive on Aug - 20 - 1922.

and that death occurred, on the date stated above, at 10 - 9 m.

The CAUSE OF DEATH* was as follows:
Myocardial degeneration with
decompensation.

CONTRIBUTORY (duration) 4 yrs. - mos. - ds.
Chronic Bronchitis & Emphysema
(Secondary) with Uræmia (duration) - yrs. 1 mos. - ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? - Date of -

Was there an autopsy? No

What test confirmed diagnosis? General Clin. Ex.

(Signed) Wesley C. Cole, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine Cemetery Aug 23 1922

20 UNDERTAKER

ADDRESS

Schloman & Son

1034

Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

22

1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 66991

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

8-19-22, 1922, to 8-21-1922

that I last saw him alive on 8-21-22, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

NOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

1255 North

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

22 1922

D 66992

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66992

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 E. 30th ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Robert Lee Robinson

(a) RESIDENCE. NO.

625 E. 30th

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 11th, 1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.610

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

Ralph S. Robinson

11 BIRTHPLACE OF FATHER (city or town)

Baltimore
Maryland

12 MAIDEN NAME OF MOTHER

Mary A. Chisley

13 BIRTHPLACE OF MOTHER (city or town)

Chisley
Chisley

14

Informant
(Address)Ralph S. Robinson
625 E. 30th St.

15 Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 19 22

17

I HEREBY CERTIFY, That I attended deceased from

July 29, 19 22, to Aug. 21, 19 22that I last saw him alive on Aug. 21, 19 22and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Enteric Colitis(duration) yrs. mos. 23 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. H. H., M. D.

, 19 (Address)

4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Spanner Family Cemetery, Aug 23 19 22

20 UNDERTAKER

ADDRESS

Fred L. L. L.

22 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 66993

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66993

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *1371 Delair Road Deepwater* St. *25* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *Kenwood Ave Rosptng* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH, *July 28*, 19*10* (Month) (Day) (Year)

7-AGE, *7* yrs. *5* mos. *22* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *at School* (b) General nature of industry, business, or establishment in which employed (or employer) *000*

9-BIRTHPLACE, (State or Country), *Rosptng Md*

PARENTS. 10-NAME OF FATHER, *R Howard McCormick* 11-BIRTHPLACE OF FATHER, (State or Country), *Rosptng Md* 12-MAIDEN NAME OF MOTHER, *Sophie Hedeman* 13-BIRTHPLACE OF MOTHER, (State or Country), *Bell Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *R Howard McCormick*

(Address) *Rosptng Md*

15-

Filed

Robert P. Harrison,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 20*, 192*2* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental, Central Nervous System, Hit by automobile, Accidental (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. S. H. Patten* M. D. (Coroner) *8/21/22* (Address) *508 E North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

McCormick Family Plot Aug 23, 192*2*

20-UNDERTAKER. ADDRESS

Fred E. Smith Sons Fallston

1922

Burial Permit Clerk

D 66994 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66994

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Municipal Free Hosp* ST. *129* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. *1606 - Alice Ann* ST. *Verantown Pa.*

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. *3*

mos.

ds.

How long in U. S., if of foreign birth? *7* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male wh. married

5a If married, widowed, or divorced HUSBAND of

*Stella Lodauski*6 DATE OF BIRTH (month, day, and year) *11/11/1911*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Laboren

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

Noep. Records Robert P. Harrison,

Filed

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 20 - 1922*

17

I HEREBY CERTIFY, That I attended deceased from *July 29, 1922* to *Aug 20, 1922* that I last saw him alive on *Aug 21st, 1922* and that death occurred, on the date stated above, at *12 45 a.m.*

The CAUSE OF DEATH* was as follows:

Empyema (Non Foe)

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Rosary**Aug 23 1922**John M. Weber**1803 Bank*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

22 1922

Every fact of information should be carefully supplied. Age should be stated exactly. If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

12-22-1927

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66995

CERTIFICATE OF DEATH.

66 D 66995

1-PLACE OF DEATH

City of BALTIMORE: (No. 1631 Shakespeare St. 2 Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. 1902 Aliciana St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, June 25 1879 (Month) (Day) (Year)

7-AGE, 43 yrs. 1 mos. 26 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Russia, Poland

10-NAME OF FATHER, John Symborski

11-BIRTHPLACE OF FATHER, (State or Country) Russia, Poland

12-MAIDEN NAME OF MOTHER, Carolina Szymowski

13-BIRTHPLACE OF MOTHER, (State or Country) Russia, Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Veronica Symborska

(Address) 1902 Aliciana St.

15- Robert P. Harrison,

Filed 22 1927 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 20 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Autopsy (Inquest, Autopsy, or Inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, Autopsy, or Inquiry.) and that said deceased came to death (Cause of death) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism
Died at once
(Duration) yrs. mos. ds.

CONTRIBUTORY (Second) John P. Horton (Signed) John P. Horton M. D.

(Address) Curtis Bay

*State the Disease Causing Death, or, if Death was Violent Cause, state (1) Means of Injury; and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, Aug 24, 1922

20-EMERALD John Weber ADDRESS 1803 Bank

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66996

CERTIFICATE OF DEATH.

113

D 66996

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 ALBERMORLE

ST.: 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME VERONIKA A ADOMAITIS

(2) RESIDENCE No. 127 ALBERMORLE

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10th 1922

7 AGE -- Years 3 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Non

9 BIRTHPLACE (city or town)

(State or country)

Baltimore Md.

10 NAME OF FATHER Joseph Adomaitis

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Lithvania

12 MAIDEN NAME OF MOTHER V. Paplavckas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Lithvania

14

Informant V. Adomaitis
(Address) 127 ALbermorle Street

15

Filed AUG 23 1922 ROBERT R. KRAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 18 1922, to Aug 22 1922, that I last saw him alive on Aug 22 1922, and that death occurred, on the date stated above, at A. A. m. The CAUSE OF DEATH* was as follows:

acute gastric Intoxication

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

Aug 22 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer

Aug. 23. 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas

425 S Pacast

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66997

CERTIFICATE OF DEATH.

D 66997

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1408 Asquith ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No. 1408 Asquith ST., WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 1 yr. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Strawbridge

6 DATE OF BIRTH (month, day, and year) Apr. 27 1870

7 AGE Years 52 Months 3 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hartford, Co. (State or country)

10 NAME OF FATHER Isaac Strawbridge

11 BIRTHPLACE OF FATHER (city or town) Hartford, Co. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth E. Trough

13 BIRTHPLACE OF MOTHER (city or town) Hartford, Co. (State or country)

14 Informant Mrs. Mary E. Strawbridge (Address) 1408 Asquith

15 AUG 23 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from James, 1922, to Aug. 22, 1922

that I last saw him alive on Aug. 21, 1922

and that death occurred, on the date stated above, at 4:50 p. m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Toxæmia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray & Pathology

(Signed) Charles J. Smith, M. D.

(Address) 4706 Hampden Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park Cemetery.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Henry Wood, Son 151 E. Egan St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66998

CERTIFICATE OF DEATH.

197 D 66998
Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Julia A. Little. (C).

30 -----

(Residence in Baltimore: No. 909 Argyle Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female.

4-COLOR OR RACE,

Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH,

September 21st, 1879.

(Month)

(Day)

(Year)

7-AGE,

42 yrs. 10 mos. 29 ds.

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None.

(b) General nature of industry, business, or establishment in which employed (or employer).

037

9-BIRTHPLACE, (State or Country).

Carroll Co. Md.

10-NAME OF FATHER,

Nicodemus Snowden. (C)

11-BIRTHPLACE OF FATHER, (State or Country).

Carroll Co Md.

12-MAIDEN NAME OF MOTHER,

Sarah Anderson. (C).

13-BIRTHPLACE OF MOTHER, (State or Country).

Carroll Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Graves. (C). (sister)

(Address) 909 Argyle Ave.

15-

Filled

AUG 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 19th, 1922.

(Month)

(Day)

1922 (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in the neck. Homicide shot by her husband, James W. Little. (C) who afterwards committed suicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.

(Coroner.)

Aug. 21st 1922 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Wonderland Park. August. 19, 1922.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

Mr. Robert A. Elliot 1725 S. Highland Ave.

66999

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 66999

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sam Bedford(a) RESIDENCE. NO. 301 W Ostend ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds.How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

MaleBlackSingle

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child 000

(b) General nature of industry, business, or establishment in which employed (or employer)

Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore MD

10 NAME OF FATHER

Samuel Bedford

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Esther R. Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Hospital RecordsROBERT R. KRAUTER,

15

AUG 23-1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 1922

17

I HEREBY CERTIFY, That I attended deceased from August 18, 1922, to August 21, 1922, that I last saw him alive on August 21, 1922 and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. B. Jones M. D.

Address

University Hospital

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cem.Aug 24 1922

20 UNDERTAKER

ADDRESS

Wm. Robert A. Elliott Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Epidemic

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67000

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 S. 16th)

ST. 36 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Robert M. Prumm

(a) RESIDENCE NO.

1305 S. 16th

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 31 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Sophia Prumm

6 DATE OF BIRTH (month, day, and year)

March 16-1877

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

45

5

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Mariner

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Standard Oil Co. of N. J.

9 BIRTHPLACE (city or town)
(State or country)

Russia

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town)

Not known

(State or country)

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Not known

14

Informant

Sophia Prumm

(Address)

1305 S. 16th St.

15

AUG 23 1922

Filed

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1922

17

I HEREBY CERTIFY, That I attended deceased from
Aug 20, 1922, to Aug 22, 1922
that I last saw him alive on Aug 21, 1922
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration)

yrs.

mos

2 ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chromatin

(Signed) Thomas B. Tilton M. D.

22 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Cathlamet

DATE OF BURIAL

Aug 25 1922

20 UNDERTAKER

Jerkler & Jerkler

ADDRESS 1739

Eager

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Physicians should state state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 67001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3713 Gough

ST. 26 WARD

2-FULL NAME

John Hilse

(a) RESIDENCE. No.

3713 Gough

ST. 26 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, 2 hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

John Hilse

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Minnie Gager

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant

(Address)

John Hilse
3713 Gough St

15

AUG 23 1922

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 22 1922

17

I HEREBY CERTIFY, That I attended deceased from
Aug 22, 1922, to Aug 22, 1922,
that I last saw him alive on Aug 22, 1922,
and that death occurred, on the date stated above, at 9:20 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Malformation
of Back + Chest

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Titlow, M. D.

8/22/22 Address: 3115 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oaklawn

Aug 23 1922

20 UNDERTAKER

Jirkles & Jirkles

ADDRESS

1739
Eager

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

67002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *4* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Chas. J. Hildebrand*

(Residence in Baltimore: No. *Lonsom m s* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male* 4-COLOR OR RACE *white* 5-Single, Married, Widowed, or Divorced. *Married* (Write the word.)

6-DATE OF BIRTH. *Aug 8* 18*93* (Month) (Day) (Year)

7-AGE. *29* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Salesman* (b) General nature of industry, business, or establishment in which employed (or employer). *066*

9-BIRTHPLACE. (State or Country). *Bath Me*

10-NAME OF FATHER. *Mr. L. Hildebrand*

11-BIRTHPLACE OF FATHER. (State or Country). *Penn*

12-MAIDEN NAME OF MOTHER. *Lama Darr*

13-BIRTHPLACE OF MOTHER. (State or Country). *Penn*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *D.S. Tyrrell*

(Address) *2119 Aiken St.*

15-AUG 23 1922 ROBERT R. KRAUTER,

Filed 1922 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *8.1* *20* 192*2* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held on. (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said. (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: *Fractured skull, crushed chest, broken leg, shock*

CONTRIBUTORY *shock by B90 train* (Secondary) (Duration) yrs. mos. ds.

(Signed) *W. K. Garrison* M. D. (Coroner.) *8.22. 1922* (Address) *117 W. Jarrington St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Baltimore Cemetery Aug. 23 1922

20-UNDERTAKER. ADDRESS

Wm. C. Black 922 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67003

67003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; NO. 3523 Chestnut Ave. ST. 13 WARD

2-FULL NAME George D. McCullough Jr

(a) RESIDENCE NO. 3523 Chestnut Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mary A. McCullough

6 DATE OF BIRTH (month, day, and year) Feb. 16-1854

7 AGE Years 68 Months 6 Days 0 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Geo. D. McCullough

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14

Informant

(Address)

Bertie Sullivan 3523 Chestnut Ave.

AUG 23 1922

ROBERT R. KRAUTER,

Burial Permit Clerk,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22-1922

17 I HEREBY CERTIFY, That I attended deceased from

Nov. 15, 1921, to Aug 21, 1922.

that I last saw him alive on Aug 21, 1922.

and that death occurred, on the date stated above, at 12:45 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 9 mos. 6 ds.

CONTRIBUTORY (Secondary)

Genl Debility

(duration) 4 yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) C. Thompson M. D.

1-2-1922 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Congressional Cem. Washington Aug 24 1922

20 UNDERTAKER

ADDRESS

Crownorth & Son 3617 Chestnut Ave

D 67004 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 624 Sarah Ann ST. WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 624 Sarah Ann St. 53 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widowed

6-DATE OF BIRTH

Unknown, 1858
(Month) (Day) (Year)

7-AGE

64 yrs. mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).Whites washed
0409-BIRTHPLACE,
(State or Country),

Baltimore, Md.

10-NAME OF
FATHER

Dennis Murphy

11-BIRTHPLACE
OF FATHER
(State or Country),

Md.

12-MAIDEN NAME
OF MOTHER

Rosetta Murphy

13-BIRTHPLACE
OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Mary Carter
624 Sarah Ann St.

15-

Filed 23 1922 191 ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

August 19, 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from
Aug 17 1922, to Aug 19 1922,
that I saw him alive on Aug 19 1922,
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
Stomach

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Exhaustion

(Duration) 2 yrs. mos. ds.

(Signed) J. S. Hughes
8/19/22 (Address) 637 Mosier St.*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL

Laurel Cemetery

DATE OF BURIAL

Aug 23 1922

20-UNDERTAKER

Daniel Hensley

ADDRESS

578

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67005

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Car Barn Calverton Rd. & Diamond St. Ward) 28Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas H. Holton(Residence in Baltimore: No. Diamond Ave. & Old Frederick Rd. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Married6-DATE OF BIRTH, July 6th 1886
(Month) (Day) (Year)7-AGE, 60 yrs. 1 mos. 25 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Foreman Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer), Shop B and O R. R.9-BIRTHPLACE, (State or Country), New London, Conn.PARENTS.
10-NAME OF FATHER, John Holton
11-BIRTHPLACE OF FATHER, (State or Country), Ireland
12-MAIDEN NAME OF MOTHER, Mary Shea
13-BIRTHPLACE OF MOTHER, (State or Country), Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Holton(Address) Diamond Ave. & Old Frederick Rd.

15-

AUG 23 1922

ROBERT R. KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21st 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. T. Hume M. D. (Coroner.)Aug 21 1922 (Address) 2702 Edmonson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, Aug. 24 192220-UNDERTAKER, Joseph B. Cook ADDRESS 1003 N. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67006

67006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

Registered No. C.

2-FULL NAME

James W. Little. (C).

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 909 Argyle Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH, Do not know. (Month) (Day) (Year)

7-AGE, 42 yrs. --- mos. --- ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Waiter. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland.

10-NAME OF FATHER, Washington Little. (C)

11-BIRTHPLACE OF FATHER, (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Malinda Skilyer. (C).

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant), Edna Hall. (C) (niece).

(Address), 1340 N. Mount St.

15. AUG 23 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 19th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol shot wound in the head. Suicide after shooting & killing his wife, Julia A. Little. (C).

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) J. M. Penland, M. D. (Coroner.) Aug. 21st 1922. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? Wonderland Park. August 19th, 1922.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn Aug 22, 1922

20-UNDERTAKER, ADDRESS

Edward Ruggold 1463 Carey St.

D 67007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67007

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2309 Edmondson Ave* ST.; *70* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *E. P. Cassidy*(Residence in Baltimore: No. *2309 Edmondson Ave* St.; *Baltimore* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Nov 11, 1854*

(Month)

(Day)

(Year)

7-AGE, *67* yrs. *9* mos. *11* ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto.*

PARENTS.

10-NAME OF FATHER *Patrick Cassidy*11-BIRTHPLACE OF FATHER (State or Country), *Ireland*12-MAIDEN NAME OF MOTHER *Jane Mc-Cawley*13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Augusta P. Cassidy*(Address) *2309 Edmondson Ave*

15-

ROBERT R. KRAUTER,

Filed *3* 1922

191

SUBST. PUBLIC CHIEF REGISTRAR

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH, *August 22, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *July 24, 1922*, to *Aug 21, 1922*,that I saw him alive on *Aug 21, 1922*, and that death occurred, on the date stated above, at *1 A* m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *W. R. Becker* M. D.
Aug 22, 1922 (Address) *614 N. Duvalton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Cathedral Cemetery*DATE OF BURIAL *8/25, 1922*20-UNDERTAKER *Chas. Krause & Son*ADDRESS *1100 N. Royal Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67008

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gonzales.

(Residence in Baltimore: No. 901 Park Ave. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White? 5-Single, Married, Widowed, or Divorced, Single. (Write the word.)

6-DATE OF BIRTH, Do not know. 1. (Month) (Day) (Year)

7-AGE, 20 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Mexico?

PARENTS. 10-NAME OF FATHER, Do not know. 11-BIRTHPLACE OF FATHER, (State or Country), Do not know. 12-MAIDEN NAME OF MOTHER, Do not know. 13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Police Report. (Address)

15-Filed AUG 23 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 18th. 1922. 192... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows:

Septicaemia due to gun shot wound in right chest. Justifiable homicide. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Chas. M. Reinhardt, M. D. (Coroner.) Aug. 20, 1922. (Address) 1217 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? E/S Mable, foot of Linwood Ave. Former or usual residence August 15th. 1922.

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, 19....

20-UNDERTAKER, Commissioner Health, ADDRESS AUG 23 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 67009****D 67009**

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 W. Mulberry ST.: 18 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 807 W. Mulberry ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, 4 hrs. or min. premature 4 1/2 pregnancy

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md10 NAME OF FATHER Wm H. Muhl11 BIRTHPLACE OF FATHER (city or town) (State or country) md12 MAIDEN NAME OF MOTHER Margaret Jacobs13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14

Informant (Address)

15

AUG 23 1922

ROBERT R. KRAUTER,

Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 22 1922 to Aug 22 1922that I last saw her alive on Aug 22 1922and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

premature birth
4 1/2 months miscarriage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Stoddard M. D., 19 (Address) 252 N. Payson St.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

276

MORE-001
74 D C

D 67010

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 369 St. Helena Ave ST. 21 WARD 11
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 2 yrs. 0 mos. 0 ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 19 42

I HEREBY CERTIFY, That I attended deceased from
 Aug 1st, 1922, to Aug 21st, 1922.
 that I last saw her alive on Aug 21st, 1922.

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

... (duration) yrs. mos 1 ds.

CONTRIBUTORY *Aschman*
(Secondary)

(duration) 7 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death?..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Udame Kod, M. D.
 , 19 (Address) 4704 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL

20	UNDER TAKER	0	ADDRESS
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ROBERT R. KRAUTER,

Registrar
~~Burial Permit Clerk~~

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Apoplexy
No other laborming
Condition

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67011

CERTIFICATE OF DEATH.

164 D 67011

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 Frisby ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis D. Shetta(a) RESIDENCE. No. 2809 Frisby ST., 9 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofAnna B. Shetta6 DATE OF BIRTH (month, day, and year) Feb 7 18867 AGE Years Months Days If LESS than 1 day, hrs. or min.
86 6 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None.9 BIRTHPLACE (city or town) (State or country) Switzerland10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Anna Shetta
(Address) 2809 Frisby St.Filed AUG 23 1922ROBERT M. KRAUTER,
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 192217 I HEREBY CERTIFY, That I attended deceased from Feb 5, 1922, to Aug 22, 1922that I last saw him alive on Aug 22, 1922and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

old ageCONTRIBUTORY (Secondary) Heart failure

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J. Toney M. D.
, 19 (Address) 414 1/2 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeem Aug 25 1922
20 UNDERTAKER E. G. Wudfeldt ADDRESS 501 E 22

Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21-MAT-1500 Bks.

D 67012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67012

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Garrett Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 27 N. Carey St.

ST.,

WARD)

2-FULL NAME

Evelyn Beatrice Nash.

(a) RESIDENCE NO.

775 W. Livingston St.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ys.

2

mos.

12

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

single

6 DATE OF BIRTH (month, day, and year)

April 1, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3 mos

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

not any

(b) General nature of industry, business, or establishment in which employed (or employer)

food

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Lloyd E. Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country)

va.

12 MAIDEN NAME OF MOTHER

Mattie Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

va.

14

Informant (Address)

Lloyd E. Nash
775 W. Livingston

15

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 21, 1922, to Aug 23, 1922,

that I last saw her alive on Aug. 22, 1922,

and that death occurred, on the date stated above, at 8:50 A. M.

The CAUSE OF DEATH* was as follows:

Dissemination - acute

not dysentery.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Malaria

(duration) yrs. 3 mos. ds.

18 Where was disease contracted

if not at place of death?

775 W. Livingston St

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Charles A. Warner, M. D.

, 19 (Address) 700 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Appomattox Co. Aug. 23 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 1201 W. Fayette

G 23 1922

Burial Form 18-6102

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Rec.-6-9-19-H. P. Co.-1090 Bkn.

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2813 7th Avenue ST. 12 WARD)

2-FULL NAME

Florence E. Boylan

(a) RESIDENCE. No.

2813 7th Avenue

WARD.

21 yrs.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

John E. Boylan

6 DATE OF BIRTH (month, day, and year)

August 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52 yrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

Westminster Md.

10 NAME OF FATHER

Charles Morgan

11 BIRTHPLACE OF FATHER (city or town; State or country)

Balto. Co.

12 MAIDEN NAME OF MOTHER

Margaret V. Juty

13 BIRTHPLACE OF MOTHER (city or town; State or country)

Balto. Co.

14

Informant (Address)

John E. Boylan 2813 7th Avenue

15

19

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 20 1922 to Aug 22 1922

that I last saw him alive on Aug 22 1922

and that death occurred, on the date stated above, at 245 a m.

The CAUSE OF DEATH* was as follows:

Paralysis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Cerebral Haemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. A. Richardson, M. D.

1922 (Address) 112 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Westminster Cemetery Aug. 24, 1922

20 UNDERTAKER

ADDRESS

Richard H. Curley 438 C. North Ave

D 67014

HEALTH DEPARTMENT—CITY OF BALTIMORE 001 67014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Unwornby Hospital

CITY OF BALTIMORE: (No.

Lombard & Jones

ST. 18

WARD)

2-FULL NAME

Elizabeth Sacks

(a) RESIDENCE. No.

118 S. Scott

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Walter Sacks

6 DATE OF BIRTH (month, day, and year)

1902

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Robert Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Non Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant

Mr. Robert Carr

(Address)

118 S. Scott

15

Signed

Robert P. Harrison,

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/22 1922

17

I HEREBY CERTIFY, That I attended deceased from

8/20 1922 to 8/22 1922

that I last saw him alive on 8/22 1922

and that death occurred, on the date stated above, at 1 PM.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary)

(duration) 2 yrs.

mos.

ds.

Central Annuity

(duration) yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical finding

(Signed) Leon Thordon, M. D.

19 (Address) Unwornby Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Catholic Church

Aug 25 1922

20 UNDERTAKER

ADDRESS

Geo Linnback & Son 1711 Pratt

AUG 23 1922

Burial Permit Clerk

1. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Very unusual case.
Blood pressure around
300. Not luetic.
Apoplectic.
Not traumatic.

D 67015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67015

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2613 E. Fayette

ST. 6

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Victoria M. Moore

(a) RESIDENCE. NO.

2613 E. Fayette

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

26 yrs.

mos.

27 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Allen Moore

6 DATE OF BIRTH (month, day, and year)

Dec. 24-1895

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

26

6

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

James Galt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Kathleen Lacombe

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Frank J. Galt 2613 E. Fayette

15

Filed

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8-21-22

17

I HEREBY CERTIFY, That I attended deceased from

6-1-22 to 8-21-22

that I last saw him alive on 8-20-22

and that death occurred, on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

CONTRIBUTORY (Secondary)

antenna of lung

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

findings

(Signed)

M. J. Galt, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Aug. 24, 1922

20 UNDERTAKER

ADDRESS

William G. Schaeffer 816 Monument

AUG 23 1922

Burial Permit Clerk

state should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67016

67016

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 721-W. Saratoga)

WARD 4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No. 721-W. Saratoga

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 8/16/1922 to 8/22/1922, that I last saw him alive on 8/22/1922, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Ateleclasis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

19

Registrar

Physicians should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

623 1922

Burial Permit 0122

AUG 23 1922

Physicians should state EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Bks.

D 67017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67017

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *University Hospital* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William S McDonald

(a) RESIDENCE. NO.

Hoffman & Boston St (5th Reg. Army)

WARD.

(Usual place of abode)

(If nonresident give city and State)

Length of residence in city or town where death occurred

66 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary MacDonald

6 DATE OF BIRTH (month, day, and year)

Nov 8

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

66

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Caretaker Fifth Reg. Army

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

*Baltimore
Maryland*

10 NAME OF FATHER *Thomas McDonald*

11 BIRTHPLACE OF FATHER (city or town)

Balto

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER *Elizabeth Slicer*

13 BIRTHPLACE OF MOTHER (city or town)

Balto

(State or country)

Maryland

14

Informant
(Address)

*Lewis F. Ruechardt
1441 Thorne Ind*

623

1922 Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 22 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Aug 15, 1922, to *August 22*, 1922,

that I last saw him alive on *August 22*, 1922,

and that death occurred, on the date stated above, at *6:50 P.*m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

CONTRIBUTORY
(Secondary)

(duration) ? yrs. mos. *6* ds.

Acute Cardiac Dehydration

(duration) ? yrs. mos. ds.

18 Where was disease contracted?

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Anthony V. Buchner*, M. D.

, 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem

Aug 26 1922

20 UNDERTAKER

ADDRESS

Wm Corke

502 E North

ORE ✓
91-002 ✓ 67018

D 67018

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

NAME: (No. 11 Carbide 10 St.)
State of Oregon

José M. Caballero

ST. WARD

(If non-resident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 22nd 1977

17 I HEREBY CERTIFY, That I attended deceased from
May 20th 1922, to May 21st 1922.

that I last saw him alive on May 2, 1977

and that death occurred, on the date stated above, at 1:45 m

The CAUSE OF DEATH* was as follows:

Platano & Brown
(duration) yrs. 1905

CONTRIBUTORY
(Secondary)

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death?..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) _____ M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL

UNDERTAKER	ADDRESS
------------	---------

.....
Registrar

TRIAL PERIOD OVER.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67019

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST., *2* WARD)2-FULL NAME *Mrs. Freda Grunspan*(a) RESIDENCE NO. *14 11th St*

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. — mos.How long in U. S., if of foreign birth? *30* yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *R.*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Mrs. A. Grunspan*6 DATE OF BIRTH (month, day, and year) *1887*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *65 yrs.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *037*(c) Name of employer *Russia*9 BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Benjamin Shera*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Ida Grunspan*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14

Informant (Address) *Mrs. Freda Grunspan 14 11th St City*

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8-23* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *7-23* 19 *22* to *8-23* 19 *22*that I last saw *her* alive on *8-23* 19 *22*and that death occurred, on the date stated above, at *8:25 A.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of the Esophagus(duration) *1* yrs. — mos. — ds.CONTRIBUTORY (Secondary) *Bronchitis pneumonia*(duration) *4* yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *Yes* Date of *7-27-22*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical + X-ray*(Signed) *J. O. Caldwell*, M. D.(Address) *St. Agnes Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Hebrew Washington Bldg**Aug 24, 22*

20 UNDERTAKER

ADDRESS *1127**Max Zernow**E. Balt*

Information should be furnished in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G 23 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67020

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *28* ST. *Ward* WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 16 72*7 AGE Years *66* Months *3* Days *6* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Bernard Corbary*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Mary Walsh*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14

Informant (Address) *Hosp. Rec. of*

15

AUG 24 1922

ROBERT R. KRAUTER,

Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 22 1922*17 I HEREBY CERTIFY, that I attended deceased from *Aug 22 1922* to *Aug 22 1922* that I last saw her alive on *Aug 22 1922* and that death occurred, on the date stated above, at *9:20 p.m.*

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis, Heart Failure, Coronary Artery Disease

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *6/22/22*Was there an autopsy? *No*What test confirmed diagnosis? *Signs*(Signed) *J. M. S. M. D.*19 (Address) *Maryland*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

George A. Taylor, Fulton & Layton

DATE OF BURIAL

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 67021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ellilian Dougherty

(a) RESIDENCE NO.

Unknown 2/5 Eulos Alley

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1898 ?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework D37

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

Baltimore

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Johnie Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind

12 MAIDEN NAME OF MOTHER

Annie Cuffey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind

14

Informant (Address)

Mr. Robert A. Krauter

Aug 24 1922

Filed

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1922

17

I HEREBY CERTIFY, That I attended deceased from August 21 1922, to August 22 1922, that I last saw her alive on August 21 1922, and that death occurred, on the date stated above, at 8:00 A.M., The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis (duration) 14 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) None yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed)

Clyde McNeil, M. D.

8/23/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laural Cemetery

DATE OF BURIAL

August 19 22

20 UNDERTAKER

Mr. Robert A. Elliott

ADDRESS

1728 Ashland St.

46590

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Reported pulmonary
th. in Nursing
Division.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

67022

D 67022

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Mosher ST.: 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 704 Mosher St. 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Colored

5-SINGLE,

MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

not known, 1864
(Month) (Day) (Year)

7-AGE

58

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 24 1922

ROBERT R. KRAUTER,

191. Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 22, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6, 1922, to Aug 22, 1922,

that I saw her alive on Aug 21, 1922,

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) ... yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) not known

(Duration) ... yrs. ... mos. ... ds.

(Signed) Harry Brown M. D.

Aug 23, 1922 (Address) 1501 Presbiterian

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt-Aurthur Cemetery Aug 25, 1922

20-UNDERTAKER

Mrs Robert A. Elliot, 1725-4th St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

67023

HEALTH DEPARTMENT—CITY OF BALTIMORE

67023
101-001
REGISTERED NO.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *206 Lloyd* ST., *3* WARD)

2-FULL NAME

Carmello Germano

(a) RESIDENCE NO.

206 Lloyd ST., *3* WARD

(Usual place of abode)
Length of residence in city or town where death occurred

yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)
(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 4 1918*
7 AGE *4* Years *3* Months *19* Days
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country)

10 NAME OF FATHER *Salvatore Germano*

11 BIRTHPLACE OF FATHER (city or town) *Italy*
(State or country)

12 MAIDEN NAME OF MOTHER *Regina Germano*

13 BIRTHPLACE OF MOTHER (city or town) *Italy*
(State or country)

14 Informant *Salvatore Germano*
(Address) *#206 Lloyd*

AUG 24 1922

ROBERT N. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 23 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Aug 21 1922* to *Aug 23 1922*
that I last saw him alive on *Aug 23 1922*
and that death occurred, on the date stated above, at *noon* m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Aug 23 1922* *Aug 23 1922* *4074 E. Euter* M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer

20 UNDERTAKER

Wendell Duffel & Son

DATE OF BURIAL

Aug 24 1922

ADDRESS

328 M

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Eks.

D 67024 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67024

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116-Church Ave. - Violetville)

2-FULL NAME

(a) RESIDENCE NO. 116-Church Ave. ST.

(Usual place of abode)
Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 23/22.

7 AGE

Years

Months

Days

If LESS than
1 day, 0 hrs.
or 40 min.

0

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

116-Church Ave

Baltimore, Md.

10 NAME OF FATHER

Phillip J. Vail

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Plymouth, N. C.

12 MAIDEN NAME OF MOTHER

Susie Frances Harrell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Subbalet Va

14

Informant
(Address)

Mr. Phillip Thos. Vail
116 Church St. Violetville

15

AUG 24 1922

19

ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 23 19/22

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 23, 1922, to Aug. 23, 1922.

that I last saw him alive on Aug. 23, 1922.

and that death occurred, on the date stated above, at 2:10 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Dwight P. Rowe M. D.
(Address) 904 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Baltimore St

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67025

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 N. Calvert St. ST. 11 WARD)

2. FULL NAME

Adelia Ann Staub

(a) RESIDENCE NO.

916 N. Calvert St.

(Usual place of abode)
Length of residence in city or town where death occurred

40

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Richard P. H. Staub

6 DATE OF BIRTH (month, day, and year)

Oct. 21st 1846

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

75

10

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Wheeling
W. Va.

10 NAME OF FATHER William S. Goshorn

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Wheeling
W. Va.

12 MAIDEN NAME OF MOTHER Priscilla J. Zinn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

W. Va.

14

Informant
(Address)

John T. Staub

2717 N. Calvert St.

ROBERT N. KRAUTER

AUG 24 1922

Filed

19

Bureau Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22nd 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1922, to Aug 22, 1922.

that I last saw her alive on Aug 22, 1922

and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Insufficiency
Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. P. C. ... M.D.

8 E. ... St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Graves Ridge Cemetery Aug 24th 1922

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 N. ... St.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Rks.

(Sonner)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67026

CERTIFICATE OF DEATH.

1130 67026

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 E. Hamburg ST. WARD)

2. FULL NAME

Margaret H. Sonner

(a) RESIDENCE NO.

115 E. Hamburg ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 23 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John L. Sonner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Sophia Konzi

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

John L. Sonner

AUG 24 1922

H. Wehm

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 23 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 23 1922

to Aug 23 1922

that I last saw her alive on

Aug 23 1922

and that death occurred, on the date stated above, at

12 30 P. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Yes

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

John B. Koll M. D. 1203 Light St

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery

Aug 25 1922

UNDERTAKER

ADDRESS

E. B. Harle 115 E. West

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

157856 HEALTH DEPARTMENT—CITY OF BALTIMORE 67027

67027

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO) JOHNS HOPKINS HOSPITAL 15 WARD)

2-FULL NAME Charles Cooper.

(a) RESIDENCE NO 1417 1/2 Mount St. City
(Usual place of abode)
Length of residence in city or town where death occurred Unknown yrs. mos. ds.

WARD
(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single
5a If married, widowed, or divorced HUSBAND of
(or) WIFE of Sophie Cooper (Mother)
6 DATE OF BIRTH (month, day, and year) May 27, 1922
7 AGE Years 2 Months 2 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland.

10 NAME OF FATHER Raymond Cooper.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant JOHNS HOPKINS HOSPITAL
(Address) ROBERT R. KRAUTER,
Burial Permit Clerk

15 AUG 24 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1922, to Aug 23, 1922, that I last saw him alive on Aug 23, 1922, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:
Diarrhea not dysentery

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?
(Signed) T. B. Gay, M. D.
(Address) Johns Hop Kin Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOV. St Peter Cnty Aug 25, 22

20 UNDERTAKER C. C. Wright ADDRESS 1364

MARGIN RESERVED FOR BINDING. Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67028

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 2023 E. Pratt ST. WARD)

2. FULL NAME

Sarah Kaplan

(a) RESIDENCE NO.

2023 E. Pratt ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female white Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1896

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER Harris Kaplan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER Annie Jacobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14 Informant (Address)

Jack Lewis 1439 E. Pratt St.

15

AUG 24 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1922, to Aug. 24, 1922, that I last saw her alive on Aug. 24, 1922, and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Procto-Pneumonia (Influenzal)

CONTRIBUTORY (Secondary)

Acute Cardiac Distention (duration) yrs. mos. ds. 6

18 Where was disease contracted if not at place of death?

residence

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) Mae J. Pringle, M. D. (Address) 2023 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Heaven Herring Run

20 UNDERTAKER

Jack Lewis 1439 E. Pratt St.

DATE OF BURIAL

8/24 1922

ADDRESS

MARGIN RESERVED FOR BINDER
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

D 67029

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Morland ave ST., 15 WARD)

2-FULL NAME

Yetta Crook

(a) RESIDENCE NO.

1605 Morland St.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Louis Crook
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE 64 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

10 NAME OF FATHER Isaac Grozman

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Fagel

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14

Informant
(Address)

Jack Lewis
1439 E. 14th St.

15

AUG 24 1922

ROBERT R. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1918, to Aug 24, 1922.

that I last saw him alive on Aug 23, 1922.

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY Pulmonary Edema

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael S. Abram, M. D.

. 19 (Address) 2360 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Methodist Ch.

20 UNDERTAKER Jack Lewis

1439 E. 14th St.

DATE OF BURIAL

8/25 1922

ADDRESS

MARGIN RESERVED FOR BUREAU OF VITALS. Every item of information should be stated EXACTLY. PHYSICIANS should state N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be properly classified. Exact statement of OCCUR-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

67030
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 S. Carey ST., 21 WARD)

2-FULL NAME Margaret Eichelberger

(a) RESIDENCE NO. 902 S. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 4-1921

7 AGE

Years

Months

Day

If LESS than 1 day, hrs. or min.

1

1

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

OOD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

md

10 NAME OF FATHER

Walter S. Eichelberger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

md

12 MAIDEN NAME OF MOTHER

Marie Tracey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

md

14

Informant (Address)

Walter S. Eichelberger
902 S. Carey St

15

AUG 24 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 23 1922, to Aug 23 1922.

that I last saw him alive on Aug 23 1922.

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Enteritis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Coolahan, M. D.
8/24/22 (Address) 24 N. Shilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

20 UNDERTAKER

James Lignan & Son

DATE OF BURIAL

Aug 26 1922

ADDRESS

1000 S. Paca St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67031

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 4809 Eastern Ave. 76 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 4809 Eastern Ave. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 1922

7 AGE Years 2 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Nick Legumeno

11 BIRTHPLACE OF FATHER (city or town) Greece (State or country)

12 MAIDEN NAME OF MOTHER Epate Angelinos

13 BIRTHPLACE OF MOTHER (city or town) Greece (State or country)

14 Informant (Address) Nick Legumeno 4809 Eastern Ave

15 Filed AUG 24 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23^d 1922I HEREBY CERTIFY, That I attended deceased from Aug 17th 1922, to Aug 23^d 1922,that I last saw him alive on Aug 12th 1922,

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Infantile Choking

(duration) yrs. 2 mos. ds.

CONTRIBUTORY Exhaustion (Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank C. Eldred, M. D.

19 23 1922 Address Spruill Street Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Frank C. Eldred, M. D.

MARGIN RESERVED. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67032

CERTIFICATE OF DEATH.

Registered No. 67032

1-PLACE OF DEATH

City of BALTIMORE: (No. 619 So. Bethel St. St. 2 Ward)

2-FULL NAME

(Residence in Baltimore: No. 619 So. Bethel St. St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE White	5-Single, Married, Widowed, or Divorced, (Write the word.) Married
6-DATE OF BIRTH Unknown		
7-AGE 38 yrs. 11 mos. 11 ds.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Laborer		
9-BIRTHPLACE, (State or Country). Russia, Poland		
PARENTS.	10-NAME OF FATHER Roch Skalski	
	11-BIRTHPLACE OF FATHER, (State or Country). Russia, Poland	
	12-MAIDEN NAME OF MOTHER. Unknown	
	13-BIRTHPLACE OF MOTHER, (State or Country). Russia, Poland	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15 AUG 24 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH

Aug 22, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, (inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said inquest, autopsy, or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Failure at once

CONTRIBUTORY (Secondary)

Cardiac Dropsy
(Signed) J. B. Norton, M. D.
(Coroner)

*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of injury; and (2) whether accidental, suicidal, or homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem.

August 25, 1922

20-UNDERTAKER

ADDRESS

M. J. Sadowski

405 S. Ann. St.

MARGIN RESERVED FOR BRIDGE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 Hudson ST., 1 WARD)

2-FULL NAME

Leon Muczynski

(a) RESIDENCE NO.

2402 Hudson ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

35 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Muczynski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 61 Months - Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant M. F. Sadowski for Family (Address) 708 S. ...

15 AUG 24 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from August 19, 1922 to August 22, 1922, that I last saw him alive on Aug 22, 1922, and that death occurred, on the date stated above, at 3 p. m. The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. Unknown

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank R. Januszewski, M. D.

8/22, 1922 (Address) 2431 Fair Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus Bur. Aug 25, 1922

20 UNDERTAKER

ADDRESS

M. F. Sadowski 715 S. ...

MARGIN RESERVED FOR DEATH RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

D 67034 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hospital* ST. *2* WARD)

2-FULL NAME *Margaret Schuster*

(a) RESIDENCE NO. *1836 Eastern Ave* ST. *40* WARD

(Usual place of abode) Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *unknown*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *69* — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)

10 NAME OF FATHER *Augusta Mier*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14 Informant *Bay View Hosp. Records* (Address)

15 *AUG 24 1922* ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 23 19 22*

17 I HEREBY CERTIFY, That I attended deceased from *July 29*, 19 *22*, to *Aug 23*, 19 *22*, that I last saw him alive on *Aug 23*, 19 *22*, and that death occurred, on the date stated above, at *2 30 P* m. The CAUSE OF DEATH* was as follows:

Carcinoma of uterus with general carcinomatosis. (duration) *unknown* ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *none*

(Signed) *J. Richardson Jones* M. D. 19 (Address) *Bay View Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Trinity Cemetery

20 UNDERTAKER *Girkler + Girkler*

DATE OF BURIAL

Aug 25 19 22

ADDRESS

1739 E. Cogh

WRITE PLAINLY, WITH UNFADING INK—THIS IS A FACT. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67035

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67035

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1701 N. Monmouth St. 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Zisel Scholimowitz

(Residence in Baltimore: No. 1701 N. Monmouth St. 22 yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, married (Write the word.)

6-DATE OF BIRTH, about 1869 (Month) (Day) (Year)

7-AGE, 53 yrs..... mos..... ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife (b) General nature of industry, business, or establishment in which employed (or employer), 03

9-BIRTHPLACE, (State or Country), Russia

10-NAME OF FATHER, Chas. Scholimowitz

11-BIRTHPLACE OF FATHER, (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Miriam Okney

13-BIRTHPLACE OF MOTHER, (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Morris Schaffer

(Address), 2434 Lakeview Ave.

15. AUG 24 1922

ROBERT R. KRAUTER,

102. Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 24, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastroenteritis

(Duration) yrs..... mos..... ds. CONTRIBUTORY (Secondary) acute dilatation of heart

(Signed) J. T. Hemmery, M. D. (Coroner)

(Address) 2802 Edmond St. *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Hebrew Int. Cemetery Aug. 24, 1922

20-UNDERTAKER, ADDRESS

FACT Lewis, 1439 E. Balto

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Nursery and Childs Hospt. 18 WARD)

2-FULL NAME Mildred Grammer

(a) RESIDENCE No. Nursery and Childs Hospt. 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7, 1922.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

0 3 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) *****

(c) Name of employer *****

9 BIRTHPLACE (city or town) Baltimore Maryland (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Mary Grammer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore(?) Maryland (State or country)

14

Informant (Address)

15

AUG 24 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from July 13, 1922 to Aug. 24, 1922.

that I last saw her alive on Aug. 24, 1922.

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Indigestion

(duration) 0 yrs. 4 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florence Crittenton Mission

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [Signature] M. D.

19 (Address) 3072 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

AUG 24 1922

MARGIN RESERVED—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67037 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *North Hope Remah* ST. *28th* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Randolph Paff-

(a) RESIDENCE. NO.

*North Hope Remah*ST. *28* WARD. *Tampa Florida -*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. 0 ds. How long in U. S., if of foreign birth? *Southwood* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male White Widower

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of *Mrs Paff-*6 DATE OF BIRTH (month, day, and year) *May 18 48*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

*74**0**0*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

(?) Germany

10 NAME OF FATHER

John Paff

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Ann Hart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

(?) Germany

14

Informant (Address)

*Records of North Hope Remah
North Hope, Balt. Md.*

15

Filed

AUG 24 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug/23- 19 22*

17

I HEREBY CERTIFY, That I attended deceased from

April 13th 1922, to *Aug 23* 1922that I last saw him alive on *Aug 23* 1922and that death occurred, on the date stated above, at *10.15 P.* m.

The CAUSE OF DEATH* was as follows:

*Apoplexy (Cerebral)
(P. Hemiplegia)*

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Dementia Senile

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Tampa Florida

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) *Frank J. Lanning* M. D.

19 (Address)

North Hope Remah

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Savannah Ga.**Aug-24- 19 22*

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

*100 W. NORTH AVE**WILLIAM F. WOODER, Successor*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

D 67038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D 67038

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital.* ST. *24* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Rosa Kelly*(a) RESIDENCE. NO. *14 Cold Spring Ave.* ST. *15* WARD. *Resident*
(Usual place of abode)Length of residence in city or town where death occurred *64* yrs. *3* mos. *5* ds. How long in U. S., if of foreign birth? *64* yrs. *3* mos. *2* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married.*5a If married, widowed, or divorced *Widowed* of (or) WIFE of *James B. Kelly.*6 DATE OF BIRTH (month, day, and year) *1858 May 22*7 AGE Years *64* Months *3* Days *2* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House-wife.*(b) General nature of industry, business, or establishment in which employed (or employer) *Domestic.*(c) Name of employer *None*9 BIRTHPLACE (city or town) (State or country) *Balto., Md.*10 NAME OF FATHER *John Zigler*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto., Md.*12 MAIDEN NAME OF MOTHER *Elizabeth Biddle.*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto., Md.*14 Informant *Rosa Kelly*
(Address) *14 Cold Spring Ave.*15 Filed *AUG 24 1922* ROBERT R. KRALLER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 24, 1922.*17 I HEREBY CERTIFY, That I attended deceased from *8/10*, 19*22*, to *8/24*, 19*22*.that I last saw her alive on *8/24*, 19*22*.and that death occurred, on the date stated above, at *4.20 A. m.*

The CAUSE OF DEATH* was as follows:

Diverticulitis of sigmoid c peritonitis.(duration) yrs. mos. *10* ds.CONTRIBUTORY *Acute nephritic toxemia.*
(Secondary)(duration) yrs. mos. *3* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Aug. 21, 1922*Was there an autopsy? *No.*What test confirmed diagnosis? *Operation.*(Signed) *J. Willie Guyton* M. D.19 (Address) *University Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Aug-26-1922

20 UNDERTAKER

STEWART & HUGHES COMPANY

ADDRESS

100 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67039

CERTIFICATE OF DEATH.

31 D 67039

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *532 Rosehill Teran* ST.: *9* WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louis Kraus

(a) RESIDENCE. NO.

532 Rosehill Teran ST.: *9* WARD. *Resident*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *40* yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs. Johana Elizabeth Kraus*6 DATE OF BIRTH (month, day, and year) *July 12-1863*7 AGE Years *59* Months *1* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Starcher*(b) General nature of industry, business, or establishment in which employed (or employer) *Confidential*(c) Name of employer *Self*9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Henry Kraus*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Magdalen Andes*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant (Address) *Wife, Elizabeth Kraus (wife)*
*532 Rosehill Teran*15 Filed *AUG 24 1922* *ROBERT R. KRAUTER,*

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 23* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 19*, 19 *22*, to *Aug 23*, 19 *22*, that I last saw him alive on *Aug 23*, 19 *22*, and that death occurred, on the date stated above, at *8 AM* m. The CAUSE OF DEATH* was as follows:*Cholelithiasis*
*Cholelithiasis*CONTRIBUTORY (Secondary) *Acute Pulmonary TB* (duration) *2* yrs. *0* mos. *0* ds. (duration) yrs. mos. ds. *40* ds.18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *Yes* Date of *July 2/22*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical observation*(Signed) *H. W. Fitchett*, M. D., 19 (Address) *4239 Yk Rd*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cem. *Aug 23/22*20 UNDERTAKER *STEWART & MOWEN COMPANY* ADDRESS *108 W. NORTH AVE.*
(WILLIAM F. WOODEN, Successor)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67042

CERTIFICATE OF DEATH.

X 59 D 67042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant Infirmary*) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Julius Lehman*(a) RESIDENCE. NO. *Louisburg, N.C.*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

6a If married, widowed, or divorced,

*Widowed of Mr. Julius Lehman*6 DATE OF BIRTH (month, day, and year) *May 22, 1869*7 AGE Years *53* Months *3* Days *3* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *N.Y. city*

(State or country)

10 NAME OF FATHER *Abraham Wechsler*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Heilner*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Maryland*14 Informant *Therese Koenigsberg*(Address) *2001 Lakeside Ave.*15 Filed *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 23* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 10, 19*22*, to *Aug. 23*, 19*22*.that I last saw him alive on *Aug. 23*, 19*22*.and that death occurred, on the date stated above, at *2:40 p. m.*

The CAUSE OF DEATH* was as follows:

acute cardiac dilatation and terminal pneumonia following diabetic coma and acidosis

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Urine Exam - Blood Sugar etc.*(Signed) *Edward M. Haverkamp*, M. D., 19 (Address) *Union Memorial Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto Hebrew Aug 25 1922

20 UNDERTAKER

ADDRESS

J. Ahrens & Co 1611 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY STATEMENT SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

AUG 24 1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 67043

D 67043

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 S Carey St., 16 WARD)

2-FULL NAME

(a) RESIDENCE NO. 912 S Carey

(Usual place of abode)

Length of residence in city or town where death occurred

life yrs.

mos.

ds.

How long in U. S., if of foreign birth? (If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert M. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1922

17 HEREBY CERTIFY, That I attended deceased from Aug 22, 1922, to Aug 23, 1922, that I last saw him alive on Aug 23, 1922, 6:30 p.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 21 ds.

(duration)

yrs.

mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. H. Colahan, M. D. 8/24, 1922 Address 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit 01012

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67044

CERTIFICATE OF DEATH.

129 D 67044
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 W. Franklin ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Wm R. Witts*

(Residence in Baltimore: No. 2004 W. Franklin St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Male</i>	4-COLOR OF RACE <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Married</i> (Write the word.)
6-DATE OF BIRTH <i>May 31, 1861</i> (Month) (Day) (Year)		
7-AGE <i>61</i> yrs. <i>2</i> mos. <i>23</i> ds. If LESS than 1 day,hrs. or....min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... <i>Farmer.</i>		

9-BIRTHPLACE,
(State or Country), *Virginia.*

PARENTS.	10-NAME OF FATHER, <i>Frank Witts.</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>Virginia.</i>
	12-MAIDEN NAME OF MOTHER <i>Margaret ?</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>Virginia.</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marshall Phillinger*
2004 W. Franklin St.
(Address).....

15-

Filed *Robert P. Harrison,*
1911 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 23, 1912.*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Aug. 16, 1912, to Aug. 22, 1912,
that I saw him alive on *Aug. 22, 1912,*
and that death occurred, on the date stated above, at *1:20 a.m.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.
(Duration) *4* yrs. *4* mos. *4* ds.CONTRIBUTORY (Secondary) *Heart.*
(Duration) *1* yrs. *4* mos. *4* ds.(Signed) *H. H. Dickson* M. D.
Aug. 23, 1912, (Address) *144 Monroe St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,
*Loudon Park*DATE OF BURIAL,
Aug. 25, 1912

20-UNDERTAKER

William Cook 502 E. North Ave.*Per. H. C. Pyle.*WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
N. B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state name of patient, date of death, and cause of death. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D67045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D67045

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hehren Nosh*)ST. *23* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *Jacob Block*

(Usual place of abode)

ST. *43 E. Cross St.*

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. mos. ds. How long in U. S., if of foreign birth? *28* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Ann Block*6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years *43* Months *—* Days *—* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

General Indse

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Russia*10 NAME OF FATHER *Isabel Block*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Russia*12 MAIDEN NAME OF MOTHER *Elizabeth Bernstein*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E. Cross St.

15

*AUG 25 1922**ROBERT A. KRAUTER**Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 24* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from

June 2, 19 *22*, to *Aug 24*, 19 *22*, that I last saw him alive on *Aug 24*, 19 *22*,and that death occurred, on the date stated above, at *6:30 P. m.*

The CAUSE OF DEATH* was as follows:

Subacute Bacterial endocarditis(duration) yrs. *2* mos. *21* ds.CONTRIBUTORY *Secondary Anemia* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*(?)*Did an operation precede death? *No* Date of *No*Was there an autopsy? *No*

What test confirmed diagnosis?

Blood Culture(Signed) *Isidore J. Juy*, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hehren Nosh Rd**8/25* 19 *22*

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67046

D 67046

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST.; *8* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2117 E. North Ave.* St.; *50* yrs.; *0* mos.; *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE. *white* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed* (Write the word.)6-DATE OF BIRTH. *don't know* (Month) (Day) (Year)7-AGE. *65* yrs.; *0* mos.; *0* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Retired* (b) General nature of industry, business, or establishment in which employed (or employer). *Labors*9-BIRTHPLACE, (State or Country). *Ireland*10-NAME OF FATHER. *Daniel Kennedy*11-BIRTHPLACE OF FATHER (State or Country). *Ireland*12-MAIDEN NAME OF MOTHER. *Mary Gary*13-BIRTHPLACE OF MOTHER (State or Country). *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marie Yeager*(Address) *326 E. 27th St.*

15-AUG 25 1922

Filed.....

191.....

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 27, 1922* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug. 8, 1922*, to *Aug. 27, 1922*, that I saw him alive on *Aug. 27, 1922*, and that death occurred, on the date stated above, at *7:30* m. The CAUSE OF DEATH* was as follows:*myocardial insufficiency*CONTRIBUTORY (Secondary) *Chronic Hypertension* (Duration) yrs. mos. ds.(Signed) *J. A. Scheuer* M. D. (Address) *St. Joseph's Hosp.*

*State the DISEASE CAUSING DEATH, or in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the *00* yrs. mos. ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *2117 E. North Ave.*19-PLACE OF BURIAL OR REMOVAL. *Crematorium* DATE OF BURIAL. *8/25/22*20-UNDERTAKER. *J. G. Moran* ADDRESS *3000 E. Baltimore*

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67047 167 D 67047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 1106 N. Fulton Ave. 16 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary C. Hedley

(Residence in Baltimore: No. 1106 N. Fulton Ave. St.; yrs. 5 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, <u>female</u>	4-COLOR OR RACE, <u>white</u>	5-Single, Married, Widowed, or Divorced, (Write the word.) <u>single</u>	16-DATE OF DEATH, <u>August 23</u> , 192 <u>2</u> (Month) (Day) (Year)	
6-DATE OF BIRTH, <u>Feb. 23</u> , 18 <u>71</u> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <u>inquiry</u> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <u>inquiry</u> (Inquest, autopsy or inquiry.) find that said deceased came to <u>her</u> death on the day stated above. The CAUSE OF DEATH* was as follows: <u>suicide by gas.</u>	
7-AGE, <u>51</u> yrs. <u>6</u> mos. <u>6</u> ds. If LESS than 1 day, hrs. or min.?			(Duration) yrs. mos. ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer)			CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.	
9-BIRTHPLACE, (State or Country) <u>Balto., Md.</u>			(Signed) <u>J. T. Hennessey</u> , M. D. (Coroner.) Aug. 24, 1922 (Address) <u>2702 Edmondson Ave.</u>	
PARENTS	10-NAME OF FATHER, <u>Anthony Hedley</u>	11-BIRTHPLACE OF FATHER, (State or Country), <u>City (Ind)</u>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	12-MAIDEN NAME OF MOTHER, <u>Mary E. Baker</u>	13-BIRTHPLACE OF MOTHER, (State or Country), <u>City (Ind)</u>	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.	
	14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>Ely. Hedley</u> (Address) <u>1106 N. Fulton Ave.</u>		Where was disease contracted, if not at place of death? Former or usual residence.	
15- <u>AUG 25 1922</u> FROM <u>ROBERT A. KRAUTER</u> Burial Permit Clerk			19-PLACE OF BURIAL OR REMOVAL, <u>Western</u> DATE OF BURIAL, <u>AUG 26 1922</u>	
			20-UNDERTAKER, <u>Geo W Little</u> ADDRESS, <u>2700 EDMONDSON AVE.</u>	

HEALTH DEPARTMENT—CITY OF BALTIMORE

67048

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 301 S FREMONT AVE

ST.: 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LUIGI DE.JULIO

(a) RESIDENCE. No. 301 S FREMONT AVE

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27th 1920

7 AGE 2 Years - Months 28 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Non

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New York, N.Y.

10 NAME OF FATHER Frank DeJulio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Jennie Tioiono

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank DeJulio (Address) 301 S Fremont Ave

15 File AUG 25 1922 J. E. Mehm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 22

17 I HEREBY CERTIFY, That I attended deceased from Aug 23rd, 1922, to Aug 24th, 1922, that I last saw him alive on Aug 24th, 1922, and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Laryngeal Leptothorax

18 Where was disease contracted if not at place of death? Duration yrs. mos. ds. 3 Frederick Farm, Fulton

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

8/25 1922 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer

Aug. 25th 22

20 UNDERTAKER

John Grebliauckas 425 S. Paca. S

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67049

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 Bolton St. ST. 14 WARD)

2-FULL NAME

Emma Elisabeth Gould

(a) RESIDENCE NO.

1731 Bolton St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

William Wallace Gould

6 DATE OF BIRTH (month, day, and year)

Aug. 9th 1850

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

72

0

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

Md.

10 NAME OF FATHER Samuel P. Dunsford

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Devonshire

England

12 MAIDEN NAME OF MOTHER Theresa P. Newman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Hamilton

Bermuda

14

Informant
(Address)Miss May A. Gould
1731 Bolton St.

15

File

AUG 25 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23rd 19 22

17

I HEREBY CERTIFY, That I attended deceased from
July 24th 19 22 to August 23rd 19 22.
that I last saw her alive on August 22nd 19 22
and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy and Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Hypostatic Pneumonia
(Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted At place of death
if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis
(Signed) M. Culverhouse, M. D.

(Address) 1901 Putnam Place, City.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

London Park Cem Aug 25th 19 22

20 UNDERTAKER

ADDRESS

Joseph B. Cook 403 N. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

440 67050
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 157 Dolphin ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 157 Dolphin St.; 10 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED
WIDOWED
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

15-

Filed

191.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 15th 1922, to Aug 30th 1922,

that I saw her alive on Aug 28th 1922,

and that death occurred, on the date stated above, at

The CAUSE OF DEATH was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) M. D.

Address

191.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laurel Cemetery Aug 27, 1922.

20-UNDERTAKER ADDRESS

Mrs Robert A. Elliott Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rhs.

D 67051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D 67051

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 E Federal St. ST., 17 WARD)

2-FULL NAME Bernard Jones

(a) RESIDENCE No. 436 E Federal St. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year)

7 AGE 1 Years 11 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Joseph Jones

11 BIRTHPLACE OF FATHER (city or town) va (State or country)

12 MAIDEN NAME OF MOTHER Jessie Garrett

13 BIRTHPLACE OF MOTHER (city or town) va (State or country)

14 Informant Jessie Jones (Address) 436 E Federal St

15 Filed AUG 25 1922 J. W. [Signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 19th, 1922, to Aug 23, 1922, that I last saw him alive on Aug 23rd, 1922, and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows: Convulsions and Dentition with Disordered Stomach

(duration) — yrs. — mos. — ds. CONTRIBUTORY Dentition and hot weather (Secondary) or fever (duration) yrs. ? mos. ' ds.

18 Where was disease contracted no if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? physical exam (Signed) [Signature], M. D.

, 19 (Address) 436 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Faunal Cemetery

Aug 25 1922

20 UNDERTAKER

ADDRESS

Mrs Robert A Elliott

Ashland St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67052

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 S. Monford Ave ST., 1 WARD)

2-FULL NAME Mieczyslaw Kowalewski

(a) RESIDENCE NO. 731 S. Monford Ave ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep. 8 1921 7 AGE Years Months Days 11 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Frank Kowalewski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Julia Kolabek

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Frank Kowalewski (Address) 731 S. Monford Ave.

ROBERT M. KRAUTER,

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1922, to Aug 24 1922, that I last saw him alive on Aug 22 1922

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs (Signed) J. S. M. D.

(Address) 408 S. PATOK

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

Aug 25 1922

20 UNDERTAKER JOHN M. WEBER

ADDRESS

1803 BANK ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates.

AUG 25 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67053

HEALTH DEPARTMENT—CITY OF BALTIMORE

67053

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST., *10* WARD)

2-FULL NAME

(a) RESIDENCE NO. *1409 E. Eager* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Barbra Hintenach

6 DATE OF BIRTH (month, day, and year)

Nov. 29-1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Geo. P. Hintenach

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Magdalene Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Barbra Hintenach 1409 E. Eager St.

15

AUG 25 1922

Robert A. Kauter, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 24 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug. 19, 1922* to *Aug. 24, 1922*, that I last saw him alive on *Aug. 24, 1922*, and that death occurred, on the date stated above, at *12:05 a.m.*

The CAUSE OF DEATH* was as follows:

General Peritonitis

CONTRIBUTORY (Secondary) *Ruptured Appendix* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at home*

Did an operation precede death? *Yes* Date of *Aug. 19, 1922*

Was there an autopsy? *No*

What test confirmed diagnosis? *P. S. & S. & operation*

(Signed) *J. V. Seizerich*, M. D.

19 (Address) *St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

2601g Redeemer Cem

DATE OF BURIAL

Aug 26 1922

20 UNDERTAKER

Frank G. Pink

ADDRESS

915 N. Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H9D 67055

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7308 Liberty Heights Ave WARD 28)

2-FULL NAME

Anna C. Schloegel

(a) RESIDENCE NO.

7308 Liberty Heights Ave

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 3, 1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

4

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Rev. C. A. Schloegel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Christina Fleckstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

J. E. Schloegel
7308 Liberty Heights Ave

Aug 25 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 3 - 1920 to Aug 23 - 1922. that I last saw her alive on Aug 22 - 1922, and that death occurred, on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Chronic Mania
(duration) 20 yrs. mos. ds.

CONTRIBUTORY Carcinoma of Bladder
(Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Cystoscope
(Signed) W. K. Skilling M. D.
8-24 1922 (Address) 4107 Liberty Heights

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

London Park Cem

20 UNDERTAKER

John Reiser

DATE OF BURIAL

Aug 26 1922

ADDRESS

2908 Ashmun

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67056

D 67056

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 S Poppleton ST., 18 WARD)

2. FULL NAME

(a) RESIDENCE

(Usual place of abode) No. 101 S Poppleton ST., 18 WARD

Length of residence in city or town where death occurred

yrs.

mos.

26 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 19217 AGE Years 10 Months 26 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

AUG 25 1922

ROBERT A. KRAULIER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 192217 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1922, to Aug 24, 1922, that I last saw him alive on Aug 24, 1922, and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro EnteritisCONTRIBUTORY (Secondary) Acidosis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Coolahan, M. D. 24 N. Hulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Underlaker John J. Cowan

ADDRESS

John J. Cowan 907 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state the CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificate. TION is very important.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
caution should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67057

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67057

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 E Lafayette Ave. 8 WARD)

2-FULL NAME

(s) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)

male White married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Emma C. Mabee

6 DATE OF BIRTH (month, day, and year)

July 5/1869

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

52

1

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Times

(b) General nature of industry,
business, or establishment in
which employed (or employer)

0810

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

MD

10 NAME OF FATHER

John R. Mabee

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

M. Stevenson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

MD

14

Informant
(Address)

Emma C. Mabee
1317 E. Lafayette Ave

AUG 25 1922

ROBERT H. KAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1922

17

I HEREBY CERTIFY, That I attended deceased from
June 17, 1922, to Aug 22, 1922,
that I last saw him alive on Aug 22, 1922,

and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Ex
(Signed) J. M. Lempert, M. D.

23 1922 (Address) 826 N. Carroll Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Landon Park Cemetery

Aug. 25 1922

20 UNDERTAKER

ADDRESS

George J. Ruth 1735 Hayford Ave.

D 67058 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67058

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N. Bethel St ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lillian Johnson

(a) RESIDENCE. NO.

511 N. Bethel St ST. 7 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 6 - 1912

7 AGE Years 90 9 Months 18 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Leo R Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore - Md

12 MAIDEN NAME OF MOTHER Lucie Farmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

PARENTS

14 Informant (Address) Geo R Johnson 511 N Bethel

AUG 25 1922

ROBERT A. KRAUTER

Registrar

Burial Permit Clerk. Hance.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1922

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to Aug 24, 1922, that I last saw him alive on Aug 23, 1922, and that death occurred, on the date stated above, at 6:45 p. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease (Mitral)

CONTRIBUTORY (Secondary) Probable cause Syphilis (duration) 3 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Clyde Brown, M. D. 8-25-22 (Address) 221 8th Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Protestant cemetery

20 UNDERTAKER

Edward Bryan

DATE OF BURIAL

Aug 27 1922

ADDRESS 631

Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC RECORD. PHYSICIANS SHOULD BE CAREFUL TO STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 67059

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Eastern ave ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1505 Eastern ave St.; 20 yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

black

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year) 1880

7-AGE,

42 yrs. mos. ds.

If LESS than 1 day,
...hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,
(State or Country).

Augusta Georgia

10-NAME OF FATHER,

John A. Stes

11-BIRTHPLACE OF FATHER
(State or Country),

Georgia

12-MAIDEN NAME OF MOTHER

Mary Smith

13-BIRTHPLACE OF MOTHER
(State or Country),

Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

AUG 25 1922

ROBERT R. KRAUTER,

191 Social Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 22, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 10 1922, to Aug 22 1922
that I saw him alive on Aug 8 1922

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Nathan J. Keegan

Aug 22, 1922 (Address) 117 S. Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Osburn Cemetery

DATE OF BURIAL,

Aug 26, 1922

20-UNDERTAKER

Edward Bryan

ADDRESS

1671

Arleone St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Mitral lesion heart. Ch. nephritis. High blood pressure. No hemorrhage

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septichæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hemorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67060

CERTIFICATE OF DEATH.

31 D 67060

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

520 N. Blumean

ST.;

WARD) 7

2-FULL NAME

Sarah Venerable

(Residence in Baltimore: No.

520 N. Blumean

St.; 15 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

unborn

(Month)

(Day)

1

(Year)

7-AGE,

26

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

house work 037

9-BIRTHPLACE, (State or Country),

Prince Edward Is.

10-NAME OF FATHER,

Verner Brown

11-BIRTHPLACE OF FATHER (State or Country),

Prince Edward Is.

12-MAIDEN NAME OF MOTHER

Lussen Scott

13-BIRTHPLACE OF MOTHER (State or Country),

Prince Edward Is.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Carabelli

(Address)

1024 Dumas St.

15-

AUG 25 1922

ROBERT A. KRAUTER,

191... Burial... Clark...

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

8

23, 1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I attended deceased from

March 1922, to 8/23 1922

that I saw her alive on 8/18 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

R. J. Young

M. D.

8/24, 1922 (Address) 429 E. ...

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

DATE OF BURIAL,

Burial Cemetery

Aug 23 1922

20-UNDERTAKER

ADDRESS 1631

Edward Bryan

Orleans St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *1718 Barnes* St., *7* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

David Frisby

(Residence in Baltimore: No. *1718 Barnes* St.; yrs.,..... mos.,..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *Colored* 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH. *Nov 4* 19*22*
(Month) (Day) (Year)

7-AGE, *9* yrs. *20* mos. *20* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer) *off*

9-BIRTHPLACE, (State or Country), *Baltimore Md*
520 N. Eden St

PARENTS:
10-NAME OF FATHER, *unknown*
11-BIRTHPLACE OF FATHER, (State or Country),
12-MAIDEN NAME OF MOTHER, *Berta Frisby*
13-BIRTHPLACE OF MOTHER, (State or Country), *North H. Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant).....
(Address).....

15- *AUG 25 1922* *ROBERT R. KRAUTER*
Filed, 10:..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 23* 19*22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) and that said deceased came to..... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Asphyx. Natural causes.
Convulsion for period of
3 months.
(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....
(Duration)..... yrs..... mos..... ds.
(Signed) *J. S. Haller* M. D.
(Coroner.)
Aug 25 1922 (Address) *508 E. North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Abert cemetery Aug 27 1922

20-UNDERTAKER, ADDRESS *1631*
Edward Bryan Orleans St

WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD - PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67062 HEALTH DEPARTMENT-CITY OF BALTIMORE D 67062
CERTIFICATE OF DEATH

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1737 E. 25 St. 8 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Margaret R. Murphy
(Residence in Baltimore: No. 1737 E. 25th St. Lifetime St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widow
6 DATE OF BIRTH Aug 29, 1867 (Month) (Day) (Year)
7 AGE 54 yrs. 11 mos. 7 ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) none
9 BIRTHPLACE (State or country) Balto.
10 NAME OF FATHER Jas H Mellon
11 BIRTHPLACE OF FATHER (State or country) Scotland
12 MAIDEN NAME OF MOTHER Isabel Kernan
13 BIRTHPLACE OF MOTHER (State or country) Scotland
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Stella Evans (Address) 1737 E. 25th St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 24, 1922 (Month) (Day) (Year)
17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1912 to Aug 24, 1912 that I saw her alive on Aug 23, 1912 and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows: Pernicious Anemia
Contributory (SECONDARY) Myocarditis (Duration) yrs. mos. ds.
(Signed) J. J. 25, 1912 (Address) 2530 M. St. M. D.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence
19 PLACE OF BURIAL OR REMOVAL Cathedral Cemetery DATE OF BURIAL Aug 28, 1922
20 UNDERTAKER Chas. W. W. 118 W. N. Keyal Ave ADDRESS

AUG 25 1922

15 ROBERT A. KRAULER, REGISTRAR
1912 Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Municipal Hospital* ST. *15* WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town, State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town, State or country)

14

Informant (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 24 1922*17 I HEREBY CERTIFY, that I attended deceased from *Aug. 21 1922* to *Aug. 24 1922*, that I last saw him alive on *Aug. 24 1922* and that death occurred, on the date stated above, at *3:25 P. m.*

The CAUSE OF DEATH* was as follows:

*Carcinoma of stomach*CONTRIBUTORY (Secondary) *Metastases to liver* (duration) *1* yrs. *1* mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

8/26/1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

AUG 25 1922

Filed

19

Burial Permit Clerk Registrar

1203 PRESTMAN ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67065

CERTIFICATE OF DEATH.

45 D 67065

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 W. Lafayette ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ella Palmore

(a) RESIDENCE. NO.

1302 W. Lafayette ST. 16 WARD.Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 0 ds. Now long in U. S., if of foreign birth? 65 yrs. 10 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofWalter J. Palmore

6 DATE OF BIRTH (month, day, and year)

Oct-7-1886

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.651017

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none9 BIRTHPLACE (city or town)
(State or country)Harpers Ferry
W. Va.

10 NAME OF FATHER

Frank P. Maury11 BIRTHPLACE OF FATHER (city or town)
(State or country)Harpers Ferry
W. Va.

12 MAIDEN NAME OF MOTHER

Mary J. Smallwood13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Harpers Ferry
W. Va.

14

Informant
(Address)Mr. Roy B. Palmore (son)
313-E University Parkway

15

Filed Aug 25 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 24.19 22

17

I HEREBY CERTIFY, That I attended deceased from

June, 1922, to Aug 24, 1922that I last saw him alive on Aug 24, 1922.and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lymphatic
initial insufficient
(duration) 12 yrs. 6 mos. 6 ds.CONTRIBUTORY
(Secondary)Gangrene of right leg
(duration) 1 1/2 mos. 6 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

E. S. Murr M. D.15, 1922 (Address)801 N. E. 1st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Druid Ridge CemeteryAug 26 1922

20 UNDERTAKER

MOWEN COMPANY

ADDRESS

108 W. NORTH AVE

WILLIAM F. WOODEN, Successor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. - 1-10-21-M&T-1500 Bks.
N. B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD - PHYSICIANS should state DATE and PLACE of DEATH EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec. - 1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174 D 67066

1-PLACE OF DEATH D 67066
CITY OF BALTIMORE: (No. *Mersey St.* ST., *5* WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John Terpin*
(a) RESIDENCE NO. *134 East St.* ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>Col.</i>	5 Single, Married, Widowed, or Divorced, (write the word) <i>Single</i>
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		
6 DATE OF BIRTH (month, day, and year) <i>March 30/1863</i>		
7 AGE <i>59</i> Years <i>3</i> Months <i>19</i> Days	If LESS than 1 day, hrs. or min.	
8 OCCUPATION OF DECEASED <i>Sabon</i>		
(a) Trade, profession or particular kind of work		
(b) General nature of industry, business, or establishment in which employed (or employer)		
(c) Name of employer		

9 BIRTHPLACE (city or town) (State or country) *Baltimore*

10 NAME OF FATHER *Joseph Terpin*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Mary*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14 Informant (Address) *Robert A. Krauter*

15 *AUG 25 1922* *ROBERT A. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 19 1922*

17 HEREBY CERTIFY, That I attended deceased from *Aug 12 1922* to *Aug 19 1922* that I last saw him alive on *Aug 19 1922* and that death occurred, on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis.

(duration) *5(?)* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Uremia* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *No*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Sig. & Seg. 800 ag. w. M.D.*

(Signed) *M. J. Stapp*

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL
ADDRESS
AUG 25 1922

UNIVERSITY OF MARYLAND

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 ST., 12 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

7 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs Mary Durbin

6 DATE OF BIRTH (month, day, and year)

May 15, 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Old

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

W. Va.

10 NAME OF FATHER

Francis Durbin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Abigail Pickens

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W. Va.

14

Informant (Address)

Mrs Mary Durbin 3405 Adenshan

15 AUG 25 1922

ROBERT A. MAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 18, 1922 to Aug 24, 1922

that I last saw him alive on Aug 13, 1922

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

West Cathedral

20 UNDERTAKER

Jos J. Oakes & Sons

DATE OF BURIAL

8/26/1922

ADDRESS

1318 E. Pratt St

D 67068 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 67068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 9 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wesley L. Peacock.(Residence in Baltimore: No. 1716 Abbottston St. St.; yrs. 14 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Married6-DATE OF BIRTH July 17, 1869. 1. (Month) (Day) (Year)7-AGE, 53 yrs. 1 mos. 6 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Plasterer.
(b) General nature of industry, business, or establishment in which employed (or employer) 0579-BIRTHPLACE, (State or Country), Pennsylvania.10-NAME OF FATHER, Wesley L. Peacock.11-BIRTHPLACE OF FATHER, (State or Country), Pennsylvania.12-MAIDEN NAME OF MOTHER, Lindsey.13-BIRTHPLACE OF MOTHER, (State or Country), Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna G. Peacock. (wife).(Address) 1716 Abbottston St.15- AUG 25 1922.Filed 1922 H. M. Rouzon Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH August 28rd. 1922. 192. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.(Duration) yrs. 5 mos. 5 ds.CONTRIBUTORY (Secondary) Cardiac Failure.(Signatures) Otto M. Reinhardt M. D. (Coroner.)Aug. 24, 1922. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Woodlawn Cemetery Aug. 26 1922

20-UNDERTAKER. ADDRESS

H. M. Rouzon 2238 W. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

67069 HEALTH DEPARTMENT—CITY OF BALTIMORE 67069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 1539 So. Clinton St., Ward) Registered No. C.....
2-FULL NAME Catherine Rolling
(Residence in Baltimore: No. 1539 So. Clinton St. 35 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX. Female	4-COLOR OR RACE. Black	5-Single, Married, Widowed, or Divorced. Widowed	16-DATE OF DEATH, Aug 24 1922 (Month) (Day) (Year)	
6-DATE OF BIRTH, March 17 1867 (Month) (Day) (Year)			17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows: Paralysis Heart or oncl (Duration) yrs. mos. ds.	
7-AGE, 55 yrs. 5 mos. 7 ds. If LESS than 1 day, hrs. or min.?			CONTRIBUTORY (Secondary) (Signed) Thos. B. Norton, M. D. Aug 25 1922 (Address) Curtis Bay	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Housewife			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Bald, Md	
9-BIRTHPLACE, (State or Country), Md			18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?	
PARENTS.	10-NAME OF FATHER, Thos. Anderson		Former or usual residence	
	11-BIRTHPLACE OF FATHER, Md		19-PLACE OF BURIAL OR REMOVAL, Asbury	
	12-MAIDEN NAME OF MOTHER, Mary Smith		DATE OF BURIAL, Aug 25 1922	
	13-BIRTHPLACE OF MOTHER, Md		ADDRESS 1502 Monument	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Emma F. Badger (Address) 1539 So. Clinton St.				
15- Robert P. Harrison, Registrar.				

UG 25 1922

Burial Permit Clerk.

Ch. Valvular Heart Disease

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyemia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicemia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AUG 25 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

67070

67070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: No. 1820 Alice Anne St. Ward 2

Registered No. C. 90

2-FULL NAME Ludwika Guzenski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1820 Alice Anne St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-Single, Married, Widowed, or Divorced. Widowed (Write the word.)

6-DATE OF BIRTH. Unknown 1. (Month) (Day) (Year)

7-AGE. about 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housework (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Poland

10-NAME OF FATHER. Michael Muszanowski

11-BIRTHPLACE OF FATHER. Poland (State or Country).

12-MAIDEN NAME OF MOTHER. Mary Nicholski

13-BIRTHPLACE OF MOTHER. Poland (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Muszanowski

(Address) 508 So. Mount Vernon

15- Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 24 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Heart Failure at once

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(Signed) J. B. Norton M. D. (Duration) yrs. mos. ds.

(Address) Curtis Bay, Balt.

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

St. Stanislaus Cem Aug 26 1922

20-UNDERTAKER, ADDRESS

M. F. Sadowski 705 S. Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST., *7* WARD)

2-FULL NAME

Frank A. McShane(a) RESIDENCE NO. *2521 Ashland* ST., *7* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

*Frances McShane*6 DATE OF BIRTH (month, day, and year) *Mar 2-1877*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Dr. James McShane*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Sarah E. Bradley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Robert McShane 2521 McShane St.

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 22 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug. 11, 1922* to *Aug. 22, 1922* that I last saw him alive on *Aug. 22, 1922*and that death occurred, on the date stated above, at *10:45 p. m.*

The CAUSE OF DEATH* was as follows:

*General peritonitis*CONTRIBUTORY (Secondary) *Ruptured Appendix* (duration) yrs. mos. ds. *11* ds.18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *yes* Date of *Aug. 11, 1922*Was there an autopsy? *no*What test confirmed diagnosis? *S.A.P.S. - operation*(Signed) *J. V. Sezerliecki*, M. D.19 Address *St. Joseph's Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

*J. A. Moran*ADDRESS *3000**E. Battell*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

AUG 25 1922

D 67072 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67072

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 N. Gilman St.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 630 1526 Harlem Av St.; 50 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH,

....., 1.....
(Month) (Day) (Year)

7-AGE,

about 50 yrs. 2 mos. 1 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

191.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug. 24, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2, 1922, to Aug 24, 1922, that I saw her alive on Aug 24, 1922, and that death occurred, on the date stated above, at 8 A. M. The CAUSE OF DEATH* was as follows:

Ch. Myocarditis and uremia
(Duration) 1 1/2 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. P. Reeves M. D.
Aug 24, 1922 (Address) 614 N. Guilford Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

25 1922

Burial Permit

67073

HEALTH DEPARTMENT—CITY OF BALTIMORE

44D 67073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1184 Cleveland St

ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Vahle

(a) RESIDENCE. No. 1184 Cleveland St

ST. 21 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Vahle

6 DATE OF BIRTH (month, day, and year) Oct 22-1884

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 37 10 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

10 NAME OF FATHER Henry Vahle

11 BIRTHPLACE OF FATHER (city or town) Balto. Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Becker

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant Mary Vahle (Address) 1184 Cleveland St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 20 1922, to Aug 23 1922, that I last saw him alive on Aug 23 1922, and that death occurred, on the date stated above, at 3 A M m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Pancreatitis) Exhaustion (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1922

Was there an autopsy? No

What test confirmed diagnosis? (Signed) J. E. Gump M. D.

8.24.1922 Address 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Aug 26 1922

20 UNDERTAKER ADDRESS

Wm J. Lickner KxPa

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

UG 25 1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67074

D 67074

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Garrison Ave ST. 15 WARD)2-FULL NAME Nancy Jeanne Warner(a) RESIDENCE NO. 1604 Garrison ST. 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6 DATE OF BIRTH (month, day, and year)

7a If married, widowed, or divorced HUSBAND of (or) WIFE of

7 AGE Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Filed

Robert P. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1922, to Aug 25, 1922, that I last saw her alive on Aug 24th, 1922, and that death occurred, on the date stated above, at 9 P.M. m. The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) S. R. Foster, M. D.19 (Address) 1017 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER Bellenger & Co Aug 25 19222122 Harrison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

25 1922

Burial Permit Blank

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Etiology unknown

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 Harwood ST., 47 WARD)2-FULL NAME Mary Mc Fague(a) RESIDENCE. No. 335 Harwood ST.,

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 18757 AGE Years 47 Months 3 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buyer(b) General nature of industry, business, or establishment in which employed (or employer) Hub Co

(c) Name of employer

9 BIRTHPLACE (city or town) Mass (State or country)10 NAME OF FATHER James S. Mc Fague11 BIRTHPLACE OF FATHER (city or town) Mass (State or country)12 MAIDEN NAME OF MOTHER Mary Isidore13 BIRTHPLACE OF MOTHER (city or town) Mass (State or country)14 Informant (Address) Maurice Mc Fague
Boston Mass15 Filed Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8.25 192217 I HEREBY CERTIFY, That I attended deceased from 8.12, 1922, to 8.25, 1922that I last saw him alive on 8.24, 1922and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

mitral insufficiency(duration) 5 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) unimpaired yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? stethoscope(Signed) R. P. Wilson, M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL South Station Boston DATE OF BURIAL 8/16/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 UNDERTAKER William CoyleADDRESS 502 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS SHOULD BE STATED EXACTLY. AGE SHOULD BE CAREFULLY SUPPLIED. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

AUG 25 1922

Wilson Burial 1124 W. Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67076

CERTIFICATE OF DEATH.

38 D 67076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hospital* ST., WARD)

2-FULL NAME *Schaefer, John A*

(a) RESIDENCE NO. *750 W. Hamburg* ST., WARD

(Usual place of abode)
Length of residence in city or town where death occurred *45* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed or divorced HUSBAND or WIFE *Carrie B Schaefer*

6 DATE OF BIRTH (month, day, and year) *Jan 26 1863*

7 AGE *59* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Barber*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Wash. D.C.*

10 NAME OF FATHER *Dubou*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Wash. D.C.*

12 MAIDEN NAME OF MOTHER *Dubou*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Wash. D.C.*

14 Informant (Address) *Carrie Schaefer 750 W. Hamburg*

15 Filed *Robert P. Harrison,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 24, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *March 8, 1922* to *August 24, 1922*, that I last saw him alive on *August 24, 1922*, and that death occurred, on the date stated above, at *11:50 p. m.*

The CAUSE OF DEATH* was as follows:
Terminal Bronchopneumonia

(duration) yrs. mos. ds. *11*
CONTRIBUTORY *G. P. of the insane*
(Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical & Laboratory*
(Signed) *N. J. Goldsmith* M. D.
, 19 (Address) *Bay View Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Frederick Taylor*

20 UNDERTAKER *Wm Cook*

DATE OF BURIAL

ADDRESS

See E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67077

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 S. Rose ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Katharina Eichhorst

(a) RESIDENCE NO.

524 S. Rose ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OF RACE White 5 Single, Married, Widowed, or Divorced Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMartin Eichhorst6 DATE OF BIRTH (month, day, and year) Oct 107 AGE Years Months Days If LESS than 1 day, hrs. or min. 90

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Adolf Springer11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Gumborn13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant (Address) Conrad Eichhorst
524 S. Rose

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1922

17 I HEREBY CERTIFY, That I attended deceased from

1918, 1922, to Aug 25, 1922that I last saw her alive on Aug 23, 1922and that death occurred, on the date stated above, at 7:40 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Physical(Signed) Rev. Heller, M. D.825, 1922 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

St. Carmel Aug 27

20 UNDERTAKER ADDRESS

Wm Cook 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCASION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

106 25 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1016 N. Cross St. ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1016 N. Cross St. ST.: _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year)

7 AGE _____ Years _____ Months 8 Days 24 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Balt Md10 NAME OF FATHER Thomas Donnelly11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md12 MAIDEN NAME OF MOTHER Catherine Lusby13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md14 Informant Catherine Donnelly (Address) 1016 N. Cross St.

AUG 26 1922

ROBERT A. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 19 2217 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1922, to Aug 24, 1922, that I last saw him alive on Aug 24, 1922, and that death occurred, on the date stated above, at 1.15 P. m.
The CAUSE OF DEATH* was as follows:Gastro Enteritis(duration) _____ yrs. _____ mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Robt J. Murray, M. D.8-25, 1922 (Address) 1510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery Aug 28 1922

20 UNDERTAKER

Geo Leimbach & Son 687 N. Pratt

N. B.—WRITE PLAINLY, WITH CAPITALS, IN INK. PHYSICIAN should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67086

67086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

Cor. Lombard & Green STS 13

WARD)

2-FULL NAME

Issac Blumenfeld

(a) RESIDENCE. NO.

827 West 34th

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Mary Blumenfeld

6 DATE OF BIRTH (month, day, and year)

Aug 5 1850

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

72 yrs.

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Clothing Cutter

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

Issac Blumenfeld

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant

S. Blumenfeld

(Address)

1010 J. North West Ave. D.C.

AUG 26 1922

Burial Permit Clerk Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/25

12

17

I HEREBY CERTIFY, That I attended deceased from

July 21, 1922, to August 25, 1922

that I last saw him alive on August 25, 1922

and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Uremia.

CONTRIBUTORY
(Secondary)Chronic Benign Prostatitis
Hypertrophy18 Where was disease contracted
if not at place of death?

Did an operation precede death? yes Date of July 22

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Willis Guyton, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balt. Hebrew Cem.

8/27/22

20 UNDERTAKER

David Sondheim

ADDRESS

118 W. Mt

Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67081

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 E. 22nd ST., 17 WARD)

2-FULL NAME

(a) RESIDENCE NO. 341 E. 22nd ST., 17 WARD

(Usual place of abode)
Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

AUG 26 1922

ROBERT M. MORTIMER

Bureau of Health Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug. 3, 1922, to Aug. 24, 1922, that I last saw him alive on Aug. 24, 1922, 10 A. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Plant Balto. Dry Docks Ward)

2-FULL NAME Frederick L. Voelker

(Residence in Baltimore: No. 2 N. Clinton St. St.; yrs. 22 mos. 6 ds.)

Registered No. C. 67082

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male. 4-COLOR OR RACE White. 5-Single, Married, Widowed, or Divorced. Married.
(Write the word.)

6-DATE OF BIRTH February 15th. 1900.
(Month) (Day) (Year)

7-AGE 22 yrs. 6 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Scaler.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country). Baltimore, Md.

10-NAME OF FATHER Herman Voelker.

11-BIRTHPLACE OF FATHER (State or Country). Germany.

12-MAIDEN NAME OF MOTHER Susannah Koehler.

13-BIRTHPLACE OF MOTHER (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sadie Voelker. (wife)

(Address) 2 N. Clinton St.

15- AUG 26 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH August 24th. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signature) Otto M. Reinhardt (Coroner.)

Aug. 25th 1922 Address 17 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

1st Evangelical Cemetery Aug. 27. 1922

20-UNDERTAKER ADDRESS

W. Gander & Sons 1710 Fleet St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67083

CERTIFICATE OF DEATH.

57

D 67083

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Dinkeland Ave ST. 15 WARD)

2-FULL NAME

Joseph Gizwarek

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2005 Dinkeland Ave

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married6a If married, widowed, or divorced HUSBAND of Alice Gizwarek (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 20-68

7 AGE

Years

Months

Days

or LESS than 1 day, hrs. or min.

54 3 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman 073

(b) General nature of industry, business, or establishment in which employed (or employer)

Car cleaning

(c) Name of employer

Dept. B & O. P. R.

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

John Gizwarek

11 BIRTHPLACE OF FATHER (city or town)

Germany

12 MAIDEN NAME OF MOTHER

Barbara

13 BIRTHPLACE OF MOTHER (city or town)

Germany

14

Informant (Address)

Alice Gizwarek
2005 Dinkeland Ave

15

AUG 26 1922

ROBERT H. MRAUTER
Registrar

Supt. Frank Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 192217 I HEREBY CERTIFY, That I attended deceased from January 16, 1922 to Aug 24, 1922that I last saw him alive on Aug 23, 1922and that death occurred, on the date stated above, at 10:24 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Gentry M. D.Address 6774 Woodlawn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Clare 8/26 1922

20 UNDERTAKER

ADDRESS

Philip Herwig 2016
Clemons

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 Spalding Ave. ST. 77 WARD)

2-FULL NAME

Bertha E. Gengnagel

(a) RESIDENCE NO.

317 Spalding Ave. ST. 77 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

48 yrs.9 mos.10 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofGeo. W. Gengnagel

6 DATE OF BIRTH (month, day, and year)

Nov 14 - 73

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.48910

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Thos. E. Maasch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ger

12 MAIDEN NAME OF MOTHER

Anna M.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ger

14

Informant
(Address)Geo. W. Gengnagel
317 Spalding Ave.

15

AUG 26 1922 ROBERT W. KRAUER,
Chief Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 24 1922

17

I HEREBY CERTIFY That I attended deceased from

Aug 24 1922 to Aug 24 1922
that I last saw him alive on 8/23and that death occurred, on the date stated above, at 2 28 A. M.

18 CAUSE OF DEATH* was as follows

Coronary artery disease
following myocardial infarction
removed for 20 years
(duration) yrs. mos. ds.

CONTRIBUTOR (Secondary)

Coronary artery disease
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

Have
Henry F. Hensley
for Dr. H. Hensley
M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Balto Cemetery

20 UNDERTAKER

Philip Herwig

DATE OF BURIAL

8/26 1922

ADDRESS

2016 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS STATEMENT SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 67085 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67085

CERTIFICATE OF DEATH.

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3618 Connecticut Ave. 13 WARD

2-FULL NAME

Rheba M. Dunsmore

(a) RESIDENCE NO.

3618 Connecticut Ave. ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 30, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

3

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

AUG 26 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1922, to Aug 24, 1922, that I last saw her alive on Aug 24, 1922, and that death occurred, on the date stated above, at 9:52 p. m.

The CAUSE OF DEATH* was as follows:

Eclampsia

CONTRIBUTORY (Secondary) Enteric - Colitis (duration) yrs. mos. ds. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Macdonald, M. D.

19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

Lloyd Ridge

Aug 26, 1922

20 UNDERTAKER

Horace H. Bungee 2631 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS THE ONLY STATE PHYSICIANS SHOULD STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

D 67086 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67086

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 4 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... James C. Martin. (C). 16

(Residence in Baltimore: No. 405 Druid Hill Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, November 4, 1865. 1 (Month) (Day) (Year)

7-AGE, 56 yrs. 9 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Carrier of Newspapers. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS. 10-NAME OF FATHER, Peter Martin. (C). 11-BIRTHPLACE OF FATHER, (State or Country), Virginia. 12-MAIDEN NAME OF MOTHER, Fannie Candence. (C). 13-BIRTHPLACE OF MOTHER, (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patsy C. Martin. (C). (wife).

(Address) 405 Druid Hill Ave.

AUG 26 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25rd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above. (Inquest, autopsy or Inquiry.)

The CAUSE OF DEATH* was as follows:

Fracture of the skull. Street car accident.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) W. M. Reinhardt, M. D. (Coroner.) Aug. 24, 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

accident North Ave & Etting St.

Former or usual residence, August 23, 1922.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

20-UNDERTAKER, Address 378

James H. Biddle

D 67087 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 947 Walnut ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Louise Britton(a) RESIDENCE NO. 947 Walnut ST., 17 WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of Charles Britton6 DATE OF BIRTH (month, day, and year) 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland10 NAME OF FATHER unknown11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)12 MAIDEN NAME OF MOTHER unknown13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14

Informant Mary A. Branch(Address) 947 Walnut St.

ROBERT H. KRAUTH

AUG 26 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 192217 I HEREBY CERTIFY, That I attended deceased from June 25th, 1922, to Aug 24th, 1922, that I last saw her alive on Aug 23, 1922, and that death occurred, on the date stated above, at 3:10 p. m.

The CAUSE OF DEATH* was as follows:

High Central Hemorrhage and Hemiplegia (duration) — yrs. — mos. — ds.
CONTRIBUTORY Pulmonary Embolism (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Symptoms
(Signed) Edward F. Mackenzie M. D.
8/25, 1922 (Address) 1339 W. North St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Laurel Cem. Aug 26 1922
UNDERTAKER Sam'l Hensley & Co. ADDRESS 578

N. B.—WRITE PLAINLY, WITH CARE, AND IN FULL. PHYSICIANS SHOULD STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE **67088**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 Byrd.)2-FULL NAME William Neill 2nd(a) RESIDENCE. No. 1728 Byrd.
(Usual place of abode)Length of residence in city or town where death occurred 77 yrs. 5 mos. 16 ds.REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 24th WARDST. 24th WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary V. Neill6 DATE OF BIRTH (month, day, and year) March 7, 18457 AGE Years Months Days If LESS than 1 day, hrs. or min.
77 5 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

(none for past 9 years)

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Maryland10 NAME OF FATHER William Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown
Ireland12 MAIDEN NAME OF MOTHER Margaret McElheney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown
U. S. A.

14 Daughter Informant

Christina Neill

(Address)

1728 Byrd St.

AUG 26 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23, 192217 I HEREBY CERTIFY, That I attended deceased from August 18, 1922, to August 23, 1922 that I last saw him alive on August 23, 1922 and that death occurred, on the date stated above, at 640 P. m. The CAUSE OF DEATH* was as follows:Valvular Heart Disease(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner M. D., 19 (Address) 1293 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western AveAug 26, 1922

20 UNDERTAKER

Margaret L. Hynes

N. B.—WRITE PLAINLY, WITH CAPITAL LETTERS. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67089

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Jackson(a) RESIDENCE NO. 233 Druid Hill Ave. ST. 11 WARD 11
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19017 AGE Years Months Days If LESS than 1 day, hrs. or min.
21 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER William Jackson11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina12 MAIDEN NAME OF MOTHER Susie Jackson13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records,15 Aug 26 1922 ROBERT H. HAAUTER,Filed 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 19 2217 I HEREBY CERTIFY, That I attended deceased from August 22, 19 22 to August 23, 19 22, that I last saw him alive on August 23, 19 22, and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary TuberculosisCONTRIBUTORY (Secondary) Chronic nephritis
(duration) 2 yrs. 7 mos. 1 ds.
(duration) 5 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Muench M. D.9/29/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 19
AUG 26 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS SHOULD STATE EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, 11 WARD)2. FULL NAME Geraldine Gillian(a) RESIDENCE NO. 520 Park Ave City
(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

How long in U. S., if not foreign birth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND of(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 11, 19227 AGE Years 1 Months 11 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Henry Gillian11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.12 MAIDEN NAME OF MOTHER Virginia Brown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14

Informant JOHNS HOPKINS HOSPITAL
(Address) Records

15

AUG 26 1922ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 22, 1922 to Aug 22 1922, that I last saw her alive on Aug 22 1922, and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

AUG 26 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS SHOULD STATE EXACTLY. AGE should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67091

CERTIFICATE OF DEATH.

D 67091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hosp 12* WARD)

2-FULL NAME

Matthew W Adams

(a) RESIDENCE No.

2917 St Paul

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Laura V. Adams

6 DATE OF BIRTH (month, day, and year)

Jan 19, 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

7

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lighterage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

James O. Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Vashiti Marine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Charles A Haslop 2917 St Paul St

15

AUG 26 1922

ROBERT A. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 25 1922

17

I HEREBY CERTIFY, That I attended deceased from *Aug 17*, 1922, to *Aug 25*, 1922,

that I last saw him alive on *Aug 25*, 1922,

and that death occurred, on the date stated above, at *1:20 P* m.

The CAUSE OF DEATH* was as follows:

*Uremic Coma
Cerebral Hemorrhage*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Int Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Symptoms*

(Signed) *W. H. Haslop*, M. D.

, 19 (Address) *1003 Madison Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Druid Ridge Aug 28 1922

UNDERTAKER

ADDRESS

John Mitchell 1201 N. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67092

D 67092

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *927 S. Kenwood* ST.: *1* WARD)2-FULL NAME *Anna. Harley.*(a) RESIDENCE. NO. *927 S. Kenwood* ST.: *1* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 5 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) *" "*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *George R. Harley*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Babio*12 MAIDEN NAME OF MOTHER *Lofie Cemy*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Geo. R. Harley*15 *AUG 26 1922*

ROBERT R. KRAUTER,

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 25 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug. 21 1922* to *Aug. 25 1922*, that I last saw her alive on *Aug. 25 1922*, and that death occurred, on the date stated above, at *7 P.* m.

The CAUSE OF DEATH* was as follows:

Tubercular meningitis.(duration) yrs. mos. *20* ds.

CONTRIBUTORY (Secondary)

Myocardial insufficiency(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical Signs*(Signed) *D. B. Bromshar*, M. D.Address *3037 Odumell St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Mt. Carmel**Aug 26 1922*

20 UNDERTAKER

ADDRESS

J. F. Halliwell 1000 S. Kenwood

N. B.—WRITE PLAINLY, WITH CARE. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

113 D 67093

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Reynolds ST., 24 WARD)

2-FULL NAME

Henry Leszczynski

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1310 Reynolds

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (Write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

"Jan 20-21"

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

125

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Frank Leszczynski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Catherine Jomien

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Frank Leszczynski
1310 Reynolds St

15 AUG 26 1922

Filed

19

ROBERT A. MAUTER,

Buchal Frank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25, 1922

17

HEREBY CERTIFY, That I attended deceased from Aug. 21, 1922 to Aug. 25, 1922, that I last saw him alive on Aug. 25, 1922, and that death occurred, on the date stated above, at 10 p. m. The CAUSE OF DEATH* was as follows:

Enteritis(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) E. S. Marr M. D.

826, 1922 (Address)

801 V. E. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

Holy RosaryAug 26 1922

UNDERTAKER

Haykowski 168 Eastern Ave

N. B.—WRITE PLAINLY, WITH CARE, AND IN INK. PHYSICIANS SHOULD STATE EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (JOHNS HOPKINS HOSPITAL. 7 ST. WARD)

2-FULL NAME

William H. Gallagher Jr.

(a) RESIDENCE NO.

Joppa Rd. 7 Camden ST. WARD Md.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

12 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 6-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lab. asst.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Wm. H. Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Lena Du Val

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

AUG 26 1922

ROBERT H. KRAUTER,

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 25 1922

17

HEREBY CERTIFY, That I attended deceased from

Aug 13 1922, to Aug 25 1922.

that I last saw him alive on Aug 20 1922.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery not dysentery

(duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

none

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Child vomited + stools were loose

(Signed)

J. B. Gay -

M. D.

, 19

(Address)

Johns Hopkins Hop

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Parkwood Cemetery

DATE OF BURIAL

Aug 26 1922

20 UNDERTAKER

Fred. L. L. Sons & Fullerton

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67095

HEALTH DEPARTMENT—CITY OF BALTIMORE

67095

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4503 Fernhill Ave. ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lydia Rosena Wilhide

(a) RESIDENCE NO.

4503 Fernhill Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Morris N. Wilhide

6 DATE OF BIRTH (month, day, and year)

Sept. 27, 1871

7 AGE

Years

Months

Days

If LESS than
1 day,hrs.
ormin.

50

10

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

Md.

10 NAME OF FATHER

Daniel Enser

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore

Md.

12 MAIDEN NAME OF MOTHER

Eliza A. Carr

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore

Md.

14

Informant
(Address)

Morris N. Wilhide

4503 Fernhill Ave.

15

AUG 26 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24, 1922

17

I HEREBY CERTIFY, That I attended deceased from

5/18, 1922, to 8/23, 1922

that I last saw him alive on 8/23, 1922

and that death occurred, on the date stated above, at 7:48 P. m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardiomyopathy
Interstitial Nephritis

burial

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

D. S. Knudsen

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George Russell, M. D.

8/25, 1922 Address 3902 Groveland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Mt. Olivet Cemetery Aug. 28, 1922

20 UNDERTAKER

ADDRESS

Joseph L. Cook 1003 N. Falls St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67096

D 67096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED.

(Write the word.)

Married

6-DATE OF BIRTH.

(Month)

July

(Day)

20

(Year)

1881

7-AGE,

41

1

5

ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Charles Flater

11-BIRTHPLACE OF FATHER

(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Anna Lappe

13-BIRTHPLACE OF MOTHER

(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Lafever A. Fong

(Address),

2503 Barclay St

158 AUG 26 1922

Filed..... 191

ROBERT A. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August

(Month)

25

(Day)

1922

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug. 12 1922, to Aug. 25 1922,

that I saw her alive on Aug. 24. 1922,

and that death occurred, on the date stated above, at 9:15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration)..... yrs..... mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... Mary F. Vaglen M. D.

Aug. 26, 1922 (Address)..... 1028 Valley St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

London Park

DATE OF BURIAL.

Aug. 28, 1922

20-UNDERTAKER

J. B. Cook

ADDRESS

1003 W. 1st St

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 R 25 St. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thomas

(a) RESIDENCE. NO. 422 R 25 St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male.

4 COLOR OR RACE

white.

5 Single, Married, Widowed, or Divorced (write the word)

Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-26-1922

7 AGE

Years

Months

Days

If LESS than 1 day, 3 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Harry R. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14

Informant (Address)

Harry R. Thomas 422 R 25 St. Robert T. Harrison,

. 19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-1922

17

I HEREBY CERTIFY, That I attended deceased from

8-26-1922, to 8-26-1922

that I last saw him alive on 8-26-1922

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia 3 1/2 h
Pallid (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Allen, M. D.
8/26/22 2737 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

W. E. Cook

Aug 26 1922
H. H. Allen

B. WRITE PLAINLY, WITH UNFADING INK—THE INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE EXACTLY STATED. PHYSICIANS SHOULD STATE EXACTLY. Exact statement of OCCASION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

AUG 22 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67098

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 25 mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

Filed

19

Robert P. Harrison, Registrar

ST.: 14 WARD)

ST.: WARD.

(If nonresident give city or town and State)

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1922

17

I HEREBY CERTIFY, That I attended deceased from
June 19, 1922, to Aug 26, 1922,
that I last saw h. alive on Aug 26, 1922,
and that death occurred, on the date stated above, at 12:40 P. M.
The CAUSE OF DEATH* was as follows:

Cerebrum

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 7 ds.

(duration) yrs. 3 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

8/26/22 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S NAME SHOULD BE STATED EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

AUG 27 1922

Burial Permit Clerk

156743

HEALTH DEPARTMENT—CITY OF BALTIMORE

67099

CERTIFICATE OF DEATH.

*159-0010 67099

1-PLACE OF DEATH

CITY OF BALTIMORE: (IN) JOHNS HOPKINS HOSPITAL, 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Bell King(a) RESIDENCE NO. 224 Race St. Selma, Ala.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Single

5a If married, widowed, or divorced

HUSBAND
DECEASEDAnnie Bell King (mother)

6 DATE OF BIRTH (month, day, and year)

May 18th 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2??

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

Child

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Ala.

10 NAME OF FATHER

James King11 BIRTHPLACE OF FATHER (city or town)
(State or country)Ala.

12 MAIDEN NAME OF MOTHER

Annie Bell King13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Ala.

14

Informant
(Address)JOHNS HOPKINS HOSPITAL
RecordsRobert P. Harrison,

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 23, 1922, to Aug 22, 1922.that I last saw her alive on Aug 22, 1922.and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? AlabamaDid an operation precede death? Yes Date of June 27, 1922
July 16, 1922Was there an autopsy? YesWhat test confirmed diagnosis? X-Ray(Signed) Warfield W. Jeros M. D.23, 1922 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Selma, Alabama Aug 27, 1922

20 UNDERTAKER

ADDRESS

Mrs Robert A. Elliot Ashland

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG 27 1922

D 67100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67100

1. PLACE OF DEATH

CITY OF BALTIMORE: No. *608 S. Tulton Ave* 19 WARD)

2. FULL NAME

Stephen Edgar Bryan

(a) RESIDENCE NO.

608 S. Tulton Ave ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. *9* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

*White*5 ~~Single~~, Married, Widowed,
or Divorced. (write the word)*married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Annie R. Bryan*

6 DATE OF BIRTH (month, day, and year)

JAN. 28th 1874

7 AGE

48

Years

Months

Days

If LESS than
1 day, 0 hrs.
or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Engineer*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

*B & O R.R.*9 BIRTHPLACE (city or town)
(State or country)*Elkridge*

10 NAME OF FATHER

*Amos S. Bryan*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Elkridge Md*

12 MAIDEN NAME OF MOTHER

*Sallie Chaney*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Elkridge Md*

14

Informant
(Address)*Annie R. Bryan
608 S. Tulton Ave*

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8-25th 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1922, to *Aug 20*, 1922,that I last saw him alive on *Aug 20*, 1922,and that death occurred, on the date stated above, at *1:15* A. m.

The CAUSE OF DEATH* was as follows:

Colon of Lung(duration) yrs. mos. *2* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

Walter A. Cox, M. D.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL*Western Cemetery*

20 UNDERTAKER

Robert. Brooks & Son

DATE OF BURIAL

8-28th 1922

ADDRESS

*Calhoun
Hollins St.*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

UG 27 1922

D 67101

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67101

CERTIFICATE OF DEATH. * 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 4. Patt. Pk Ave)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 11

mos. —

ds.

How long in U. S., if of foreign birth?

yrs. —

mos. —

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

Dec. 14, 1849

7 AGE

73

Years

Months

Days

If LESS than 1 day, hrs. or min.

8

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Thomas Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Elizabeth Mayers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Thomas Robertson, 509 Patterson Pk. Ave.

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/26/22

17

HEREBY CERTIFY, That I attended deceased from 8/14/22, 19, to 8/26/22, 19

that I last saw him live on 8/20/22

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic degenerative
cardiac asthma

CONTRIBUTORY (Secondary)

(duration) 3 yrs. — mos. — ds.

(duration) yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Albert H. Legg, M. D.

(Address)

3813 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Staunton, Va.

DATE OF BURIAL

8-27-1922

20 UNDERTAKER

Wm. Cook.

ADDRESS

502 E. North,

UG 27 1922

Burial Permit Clerk.

B.—WRITE PLAINLY, WITH UNFADING INK.—THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67102

CERTIFICATE OF DEATH.

D 67102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2204 E Pratt ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lena Sachs

(a) RESIDENCE NO.

2204 E. Pratt St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

2/ yrs.

mos.

ds.

How long in U. S., if of foreign birth?

2/ yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Edel Sachs

6 DATE OF BIRTH (month, day, and year)

Aug 1858

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.64

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Alison Zuckoff

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Sachs

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant
(Address)Hemo 1439 E Pratt St

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hehrem Brook Road

DATE OF BURIAL

8/27 1922

20 UNDERTAKER

Jack Lewis 1439 E Pratt St

—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG 27 1922

19

Registrar

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67103

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Hebrew Hospital* ST. *6* WARD)

2-FULL NAME *Moses Cohen*

(Residence in Baltimore: No. *1753 Orleans Street*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

20 yrs., *20* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

M

6-DATE OF BIRTH,

June 5, 1870
(Month) (Day) (Year)

7-AGE,

52 yrs., *2* mos., *20* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Section Hand
Cong. form. Tailor
080

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Elija Cohen

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *A. William Cohen*

(Address) *503 N. Calver St.*

15-

Robert P. Harrison

101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 25th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *death* (Inquest, au-
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Profound left side paralysis)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY *Arteriosclerosis* (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. H. Hall* M. D. (Coroner.)

Aug 26, 1922 (Address) *508 E. North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Rosedale

DATE OF BURIAL,

8-27, 1922

20-UNDERTAKER

Jack Lewis 1439 E. Balt St

ADDRESS

W. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

D 67104 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *1* Ward)

2-FULL NAME

(Residence in Baltimore: No. *619 S Bolton Ave* St.; yrs. mos. ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH. *Nov* 29 1919 (Month) (Day) (Year)

7-AGE, *2* yrs. *8* mos. *28* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *none* (b) General nature of industry, business, or establishment in which employed (or employer) *none*

9-BIRTHPLACE, (State or Country). *Balto Md*

10-NAME OF FATHER. *Michael Kupnicki*

11-BIRTHPLACE OF FATHER, (State or Country). *Poland*

12-MAIDEN NAME OF MOTHER. *Magdalena Master*

13-BIRTHPLACE OF MOTHER, (State or Country). *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Michael Kupnicki*

(Address).....

15-

Filed *Robert P. Harrison,* 192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Aug* 26 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Death followed by asphyxiation. Choking was caused by foreign body in throat.

(Duration) yrs. mos. ds.

CONTRIBUTORY *Septicemia suspected* (Secondary) *Culture not yet reported*

(Duration) yrs. mos. ds.

(Signed) *S. H. Haller* M. D.

(Coroner) *S. H. Haller* (Address) *508 E. North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL,

St Stanislaus *Aug 27* 1922

20-UNDERTAKER, ADDRESS

John M. Weber *1803 Bank St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 E 29th St. ST. 9 WARD)2-FULL NAME Charlotte G. Knott(a) RESIDENCE NO. 1824 E 29th St. ST. 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 13 mos. 23 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

REGISTERED N.C.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of -6 DATE OF BIRTH (month, day, and year) July 3, 19217 AGE Years 1 Months 1 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Chas J Knott11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Corra S. Pickett13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant Chas J. Knott (Address) 1824 E 29th St.

15

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1922, to Aug. 26, 1922; that I last saw her alive on Aug. 26, 1922, and that death occurred, on the date stated above, at 5:40 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.
acute illis Calitis.(duration) yrs. mos. 21 ds.CONTRIBUTORY Lobar Pneumonia (Secondary)(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) Thos L. Stevens, M. D.826, 1922 (Address) 2878 Starford St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cem. Aug. 28, 1922

20 UNDERTAKER

ADDRESS

Lilly & Zeller 4033 Maple St

B.—WRITE PLAINLY, WITH CORRECT SPELLING. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PRESENT CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

8627 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 67106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Brunt ST., 14 WARD)

2-FULL NAME Pearl White

(a) RESIDENCE NO. 1704 Brunt

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1922, to Aug 23 1922, that I last saw him alive on Aug 22 1922, and that death occurred, on the date stated above, at 12.05 P. m.

The CAUSE OF DEATH was as follows:

Gastric Enteritis (acute)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

E. William Frey, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS 1343

B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

JG 27 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67107

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Ridgely Int. Wm.* ST. *11* WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred *50* yrs. *1* mos. *0* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of

Anderson Young
8/18/38

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baileys
and
Gabriel Sutton

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Albie Lewis
interview

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

8/24/22

17

HEREBY CERTIFY, that I attended deceased from

8/21/22 to *8/24/22*that I last saw him alive on *8/24/22*and that death occurred, on the date stated above, at *11 P.* m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. H. Harkins*, M. D.1922 (Address) *1216 N. H. Av.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

At Auburn *Aug 24 22*

20 UNDERTAKER

ADDRESS *1140**Brown & Thelander*

B- WRITE PLAINLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

BG 27 1922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Chronic Bright's Disease

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67108

D 67108

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St V. Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

1401 - Division

ST.

WARD

2-FULL NAME

Mary Shean

(a) RESIDENCE NO.

1401 - Division

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

Apr 21, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Not known

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

(Address)

St Vincent Infirmary
1401 Division St

15

Typed

19

Registrar

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

Cathedral Cem
Martin Hakey Son 1827 N North Ave

DATE OF BURIAL

Aug 25 1922

ADDRESS

16 DATE OF DEATH (month, day, and year)

Aug 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Apr 21, 1922, to Aug 5, 1922.

that I last saw her alive on Aug 5, 1922.

and that death occurred, on the date stated above, at 11-30 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goodborough, M. D.

, 19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

B. - WRITE PLAINLY, and CAREFULLY. AGE should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

627

1922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Malnutrition

D 67109

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67109

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Katie B. Murphy

(a) RESIDENCE. NO.

105 N. Poppleton

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *14* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*William H. Murphy*6 DATE OF BIRTH (month, day, and year) *1888*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dress maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Maryland*

10 NAME OF FATHER

*Samuel Stricker*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

*Mary Barnes*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Maryland*

14

Informant
(Address)*Richard S. Stricker
2521 - Francis St*

15

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8/26* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *8/23* 19*22*, to *8/26* 19*22*.that I last saw her alive on *8/26* 19*22*.and that death occurred, on the date stated above, at *3 20 a. m.*

The CAUSE OF DEATH* was as follows:

*Surgical Shock
Pulmonary Embolism
14 hours*CONTRIBUTORY
(Secondary)*Tracheitis Uteri*18 Where was disease contracted
if not at place of death? *not known*Did an operation precede death? *yes* Date of *8/20/22*Was there an autopsy? *yes*What test confirmed diagnosis? *clinical findings*

(Signed)

R. B. Jones

M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Mechanicville
Carroll County Md*

DATE OF BURIAL

8-28-1922

20 UNDERTAKER

*H. C. Manning & Son*ADDRESS *517 N
Schneider St*

CAUSE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

27 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67110

CERTIFICATE OF DEATH.

162 D 67110

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

E. Monument

ST.:

6

WARD)

2-FULL NAME

Baby (Boy) Belson

(a) RESIDENCE. No.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 25, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, 36 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Louis Belson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Jennie Roszovsky

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Louis Belson
212 Patterson PK Ave

Robert P. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 25, 1922, to Aug 27, 1922.

that I last saw him alive on Aug 27, 1922.

and that death occurred, on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum

(duration)

yrs.

mos.

1 1/2 yrs.

CONTRIBUTORY (Secondary)

Atelectasis (Collapse of lung)

(duration)

yrs.

mos.

1 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Edlarich, M. D.

(Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Herring Run

Aug 27 1922

20 UNDERTAKER

Max Pearson

ADDRESS 117 E

Balto Md

06 27 1922

Burial Permit Clerk.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2635 Boone St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elvora Carter(a) RESIDENCE NO. 2635 Boone St. ST., 9 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleColoredSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March - 1, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

524

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Maryland

10 NAME OF FATHER

Henry Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Mildred Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Henry Carter
2635 Boone St.

15

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 192217 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1922, to Aug 25, 1922, that I last saw him live on Aug 25, 1922, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

2nd Degree Burn of Body(duration) yrs. mos. ds. 1/2

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical Exam

(Signed)

Geo. Hall, M. D.

19

(Address)

1216 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

1303 FRESTMAN ST.

B.—WRITE PLAINLY, WITH CAPITAL LETTERS. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

AUG 27 1922

Burial Permit No.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *perituncum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

OK, J. S. Bacon MD
Coroner
Horseasson Dist
Upset some hot jelly

D 67112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor* 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Catharine Heiligman*(a) RESIDENCE. NO. *Paulton Valley St.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *52* yrs. mos.How long in U. S., if of foreign birth? *52* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow of*

5a If married, widowed or divorced

HUSBAND of
(or) WIFE of*Julius Heiligman*6 DATE OF BIRTH (month, day, and year) *May 10, 1870*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
82 *3* *15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

x

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany*
(State or country)10 NAME OF FATHER *John Batching*11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER *Margaret Stetzsch*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant *Sister Ferruccio*
(Address) *Little Sisters of the Poor*15 *Robert P. Harrison*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 26 1922*17 I HEREBY CERTIFY, That I attended deceased from *no record*
19 to 19that I last saw him alive on *Aug 20*, 1922and that death occurred, on the date stated above, at *3 a.m.*

The CAUSE OF DEATH* was as follows:

*Cerebral apoplexy**1 week* (duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *P. A. Warner*, M. D.1922 (Address) *1133 Valley St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Aug 28 1922

20 UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Greenmount

B. WRITE PLAINLY, WITH CARE. INFORMATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

27 1922

WRITE PLAINLY, WITH OMBIGS. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

67113 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 67113

67113

CERTIFICATE OF DEATH

90 REGISTERED NO. 67113

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1210 Lafayette Ave ST. 8 WARD)

2 FULL NAME Mary E O'Neil

(Residence in Baltimore: No. 1210 E Lafayette Ave Sr. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6 DATE OF BIRTH April 23, 1873 (Month) (Day) (Year)

7 AGE 79 years 3 mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housewife 037

9 BIRTHPLACE (State or country) Ireland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Nellie O'Neil

(Address) 1210 E. Lafayette Ave

15

AUG 28 1922

ROBERT A. KRAUTER,

Bureau Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 8 24, 1912 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8/14, 1911, to, 8/23, 1912

that I saw her alive on 8/23, 1912

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Contributory (SECONDARY) Arterio Sclerosis (Duration) yrs. mos. ds.

(Signed) J. J. Traub M. D. 8/26, 1912 (Address) 293/111 E. 11th

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

New Cathedral Cemetery Aug 28, 1912

20 UNDERTAKER ADDRESS

George J. Ruth 735 Haverdave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67114

CERTIFICATE OF DEATH.

D 67114

1-PLACE OF DEATH

City of BALTIMORE: (No. 1518 Prestman St., 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1518 Prestman St., yrs., 5 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-Single, Married, Widowed, or Divorced. (Write the word.) single

6-DATE OF BIRTH, March 14, 1922 (Month) (Day) (Year)

7-AGE, yrs., 5 mos., 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Domestic (b) General nature of industry, business, or establishment in which employed (or employer), Domestic

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Nathan Harmon

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Flora Brown

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Nathan Harmon

(Address), 1518 Prestman St.

15- AUG 28 1922

ROBERT R. KRAUTER

Filed, 1922

Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows:

Whooping cough (Duration) yrs., 7 mos., 7 ds.

CONTRIBUTORY (Secondary) Branchio-pneumonia (Signed) J. J. Edmunds, M. D. (Coroner.) (Address) 2802 Edmunds St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn Aug 28, 1922

20-UNDERTAKER, ADDRESS

Edward Rengold 1463 Carey

ORE ✓ 67115

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. Municipal Hospital ST., 0 WARD)

(a) RESIDENCE NO. 1314 Chester St ST., WARD (If none)

(a) RESIDENT NON-ALIEN				(11 non-resident give city or town and State)			
(Usual place of abode)							
Length of residence in city or town where death occurred	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from
August 4, 1922, to August 26, 1922.

that I last saw him alive on August 25, 1922.

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 2 yrs mos ds
CONTRIBUTORY ~~*[scribble]*~~ Psychitis
(Secondary) (duration) yrs mos ds

18 Where was disease contracted
if not at place of death?

Did an operation precede death?.....Date of.....

Was there an autopsy?

What test confirmed diagnosis? 1. 1

(Signed) Charles Marshall M. I.

8/31/2 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
--------------------------------------	----------------

MOVAL
H. L. R. [unclear] Aug 29 19

UNDERTAKER <i>W. G. Henderson</i>		ADDRESS
--	--	----------------

N UNDER TAKER
 Pst 77

John D. Turner 1942-1943

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Ambrose Hoff

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Id.

12 MAIDEN NAME OF MOTHER Mary Somers

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14	Informant (Address)	Hospital Records, Municipal Hospital
----	------------------------	---

15 ROBERT N. KRAUTER,

AUG 28 1922 Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67116

CERTIFICATE OF DEATH.

129 D 67116
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hospital* ST. WARD)2-FULL NAME *Effie Brown*(a) RESIDENCE NO. *2855 Prospect* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fem.

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

Carroll Brown

6 DATE OF BIRTH (month, day, and year)

1872

7 AGE

50

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md.*

10 NAME OF FATHER

John T. Deal

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)*Carroll Brown
2855 Prospect St*

15

Filed

AUG 28 1922

ROBERT A. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 25 1922*

17

I HEREBY CERTIFY, That I attended deceased from
August 19, 1922 to *August 25, 1922*
that I last saw her alive on *August 24, 1922*
and that death occurred, on the date stated above, at *8:20 a.m.*

The CAUSE OF DEATH* was as follows:

*Uremia*CONTRIBUTORY (Secondary) *Chronic Parenchym Neph.*
(duration) ? yrs. mos. ds.18 Where was disease contracted
if not at place of death? *?*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

DATE OF BURIAL

Aug 28 1922

20 UNDERTAKER

Robt T. Turner Inc.

ADDRESS

1442 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67117

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Mary Grecco

(a) RESIDENCE NO.

205 S. Eden St. City WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
or WIFE ofCristo Grecco (Father)6 DATE OF BIRTH (month, day, and year) Aug 29, 19217 AGE Years Months Days If LESS than 1 day, hrs. or min.
11 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Cristo Grecco

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Theresa

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

JOHNS HOPKINS HOSPITALRecords

15

AUG 28 1922ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 25, 1922, to Aug 26, 1922.that I last saw her alive on Aug 26, 1922.and that death occurred, on the date stated above, at 10:45 P. M.

The CAUSE OF DEATH* was as follows:

Dysentery Type undetermined(duration) yrs. mos. ds. 12

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

HomeDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) T. B. Gay M. D.Aug 26, 1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Soley Redeemer

DATE OF BURIAL

August 28, 1922

20 UNDERTAKER

Martin W. E. Dwyer

N. B. WRITE PLAINLY, WITH CAPITAL LETTERS. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 Seadenhall ST., 22 WARD)

2-FULL NAME

Eva Marie Little

(a) RESIDENCE NO.

829 Seadenhall ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 10 mos. 11 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caf

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct, 15, 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

11011

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Maryland

10 NAME OF FATHER

George Little

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore
Maryland

12 MAIDEN NAME OF MOTHER

Eva Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore
Maryland

14

Informant (Address)

Eva Harris
829 Seadenhall

15

AUG 28 1922ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug, 26, 22

17

I HEREBY CERTIFY, That I attended deceased from July, 28, 1922 to Aug, 26, 1922, that I last saw her alive on Aug, 25, 1922, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Dysentery + Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Terminal Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) David Friedman M. D.8/26, 1922 (Address) 122 W See St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Int. Burial

DATE OF BURIAL

Aug 28, 1922

20 UNDERTAKER

John H. Toadine

ADDRESS

142

N. B.—WRITE PLAINLY, WITH CONCISENESS. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1622 Druid Hill East* WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Garrett*(a) RESIDENCE. No. *1622 Druid Hill East* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *75* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *Caucasoid* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE *75* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *md* (State or country)10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant *Mary Garrett* (Address) *1622 Druid Hill East*15 Filed *AUG 28 1922* ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 26* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 10*, 19*22*, to *Aug 26*, 19*22*, that I last saw him alive on *Aug. 26*, 19*22*, and that death occurred, on the date stated above, at *3.30 p.m.*

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Arterio-sclerosis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edward J. Sheelley*, M. D.*8/27/1922* (Address) *1230 Druid Hill East*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

John H. Toddman ADDRESS *142 Union St*

67120
Spec. 16-12-24 P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Vincent ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Richard Bacon

(a) RESIDENCE. No.

809 Vincent

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bacon

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 40 + +

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Cement-works

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Tanier Maryland

10 NAME OF FATHER Olin Bacon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Clinton Miss.

12 MAIDEN NAME OF MOTHER Eliza Lantry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St. Louis Mo.

14 Informant (Address) Samuel Carter

15 Filed AUG 28 1922 ROBERT H. CARTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1922, to Aug 25, 1922, that I last saw him alive on Aug 24, 1922, and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) + + yrs. + mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark M. D.

(Address) 1306 W. B. Lane St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Luke's Aug 28 1922

20 UNDERTAKER ADDRESS

Samuel Carter

N. E.—WRITE PLAINLY, WITH CAREFULNESS. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

67121

CERTIFICATE OF DEATH.

REGISTERED NO. 67121

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 E Pratt ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1535 E Pratt St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Aug 27, 1922 (Month) (Day) (Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day, (hrs. or min.)

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

AUG 28 1922

ROBERT R. KRAUTER,

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 28, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 27, 1922, to Aug 27, 1922, that I saw her alive on Aug 27, 1922, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

premature birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Nathan Heggen M. D.

Aug 28, 1922 Address 1127 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Hebrew Mt. Cemetery

20-UNDERTAKER

May Levinson

DATE OF BURIAL,

Aug 28, 1922

ADDRESS

1127 E. Pratt St.

N. B.—Every item of information should be carefully supplied. AGE should be stated exactly. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67122

CERTIFICATE OF DEATH.

D 67122

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Neheem Hosh* ST.: *3101-001* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

David Friedman

(a) RESIDENCE. No.

308 S. Caroline

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Jul Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Ludie Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E. Baltimore St

15

Filed

19

*AUG 28 1922**ROBERT R. KRAUTER*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 27, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Aug. 21, 1922, to Aug. 27, 1922*that last saw him alive on *Aug. 27, 1922*and that death occurred, on the date stated above, at *10.30 P. m.*

The CAUSE OF DEATH* was as follows:

*Lobar pneumonia
Empyema*(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *(thoracentesis)*(Signed) *Isidor I. Juy* M. D., 19 (Address) *Hebrew Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Neheem Mt Carmel Rd 828 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore St

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Information should be carefully supplied. All should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1900 Bks.

HEALTH DEPARTMENT CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST.: WARD)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OF RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

19

AUG 26 1922

ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Premature Birth 8 months in Utero

Anaemic Mother

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What post mortem diagnosis?

(Signed) M. D.

19 State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated in years. Exact statement of OCCUPATION is important. See instructions on back of certificate.

67124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Clinton Foley
217 N. Calver

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE Col	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH, Dec 14, 1912 (Month) (Day) (Year)		
7-AGE, 9 yrs. 8 mos. da. If LESS than 1 day, ... hrs. or ... min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		

9-BIRTHPLACE,
(State or Country).

PARENTS.	10-NAME OF FATHER, Geo. Foley
	11-BIRTHPLACE OF FATHER (State or Country), Va.
	12-MAIDEN NAME OF MOTHER, Jennie Lall
	13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie Hall
(Address) 217 Calver St.

15-AUG 28 1922

ROBERT R. KRAUTER,
Bureau Permit Clerk

Filed..... 101.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 23, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation
I think they died either from asphyxiation or suffocation. First I did not know how long they were in there.
(Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY
(Secondary)

(Signed) M. D.
(Coroner.)
Aug 27, 1922 (Address) 1035 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... da. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel Cem

Aug 28, 1922

20-UNDERTAKER

ADDRESS

Mrs. J. G. Locks

1302 Jefferson

No 5967-8

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67125

X1230 67125

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Protestant Infirmary* ST. *14*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

David G. Deardorff

(a) RESIDENCE. NO.

York, Pa.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

7

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Mary Groves Deardorff*6 DATE OF BIRTH (month, day, and year) *June 11, 1851*

7 AGE

Years

Months

Days

If LESS than
1 day, ... hrs.
or ... min.*71**2**17*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Pennsylvania*
(State or country)10 NAME OF FATHER *David Deardorff*11 BIRTHPLACE OF FATHER (city or town) *Penn.*
(State or country)12 MAIDEN NAME OF MOTHER *Margaret Gise*13 BIRTHPLACE OF MOTHER (city or town) *Penn.*
(State or country)

14

Informant
(Address)*David G. Deardorff*
York Pa.

15

*AUG 28 1922**ROBERT N. KRAUTER,*

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 28* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Aug 22, 19 *22*, to *Aug 28*, 19 *22*,that I last saw him alive on *Aug 27*, 19 *22*,and that death occurred, on the date stated above, at *7:10 a.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia following operation for cystic stone.(duration) yrs. *3* mos. *2* ds.CONTRIBUTORY
(Secondary)*Pneumonia*(duration) yrs. mos. *3* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *Yes* (2) Date of *Aug. 23.*
*Aug. 26.*Was there an autopsy? *No*What test confirmed diagnosis? *Operation*(Signed) *Edward H. Hawahan, M.D.*, 19 (Address) *Union Memorial Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether, Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, OPERATION OR REMOVAL

DATE OF BURIAL

*York Pa.**Aug. 27 1922*

20 UNDERTAKER

*H. Jenkins, Inc. - Co.**Richard J. Holbrook*

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67126

D 67126

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 400 N. Fulton Ave. ST. 20 WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced, (write the word) Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph H. Miller

6 DATE OF BIRTH (month, day, and year) 3/20/1840

7 AGE Years 81 Months 5 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Thomas Newton

11 BIRTHPLACE OF FATHER (city or town) England (State or country)

12 MAIDEN NAME OF MOTHER Susanna Turner

13 BIRTHPLACE OF MOTHER (city or town) England (State or country)

14 Informant Helen E. Bennett Supt. (Address) 400 N. Fulton Ave.

15

AUG 28 1922

ROBERT E. KRAUTER, Registrar

Mortal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1922

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1922, to Aug 26, 1922, that I last saw her alive on Aug 20, 1922, and that death occurred, on the date stated above, at 1 P. M. The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

CONTRIBUTORY (Secondary) About 2 yrs. mos. ds. Arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. N. Duval, M. D. (Address) 1817 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER George Smith (Address) 400 N. Fulton Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67127

D 67127

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1067 Vine ST., 18 WARD)2-FULL NAME John G. Smith(a) RESIDENCE NO. 1067 Vine ST., Life WARD

(Usual place of abode)

Length of residence in city or town where death occurred

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) Janie Smith6 DATE OF BIRTH (month, day, and year) Aug. 11, 1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53-15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Henrietta Galloway

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

Janie Smith
1067 Vine St.

15

AUG 28 1922

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26, 1922

17

I HEREBY CERTIFY, That I attended deceased from 7/30/1922 to 8/26/1922 that I last saw him alive on Aug 25, 1922and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration)

Indef

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 7/30/22Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. F. Kaville

M. D.

(Address) 11971 Carrollton Ave
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Laurel GreenAug 29 1922

20 UNDERTAKER

ADDRESS 1140Lawrence Ireland Schuler

tion should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

67128

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4601 Eastern Ave ST., 76 WARD)

2. FULL NAME

(a) RESIDENCE NO. 4601 Eastern Ave ST., 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sula Klimm

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

31

10

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George Klimm

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Mary Seifert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14 Informant (Address)

Sula Klimm

4601 Eastern Ave

15 AUG 28 1922

Burial Permit Clerk

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1922, to Aug 26, 1922,

that I last saw him alive on Aug 26, 1922,

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Compromised lung - Rupture - (Hydrothorax) not tubercular

CONTRIBUTORY (Secondary) Cardiac Paralysis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of Aug 4/22

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) J. P. B. (Address) 125 S. B. Hwy

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Catharon Cem., Aug. 28 1922

20 UNDERTAKER

J. Sander & Sons 1710 E. Ave.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Probably due to a
Pneumonia*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67129

CERTIFICATE OF DEATH.

31/ 67129

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 Gough ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Henrietta Venker

(a) RESIDENCE NO.

1820 Gough St

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

James Venker

6 DATE OF BIRTH (month, day, and year) Jan 7, 1899

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

23 7 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER George T. Krollman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah Emphins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

PARENTS

14 Informant James Venker (Address) 1820 Gough St

15

AUG 28 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1922, to Aug. 27, 1922, that I last saw her alive on Aug. 26, 1922, and that death occurred, on the date stated above, at 2 a. m. The CAUSE OF DEATH* was as follows:

Haemorrhage of lungs
Tuberculosis of lungs
(duration) yrs. mos. ds.CONTRIBUTORY (Secondary) Tuberculosis of lungs
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. W. W. Krollman, M. D.

8-27-1922 (Address) 708 E. 1st St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

1820 Gough St Aug 30 1922

20 UNDERTAKER

ADDRESS

H. Sander & Son 1810 Red St

Exact statement of DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67130

CERTIFICATE OF DEATH.

67130

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. Ft. McHenry, Md.

ST. 24 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolfo D. Tossas

(a) RESIDENCE NO. San Juan, Porta Rica

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 21 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Porta Rica

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 AUG 28 1922

ROBERT N. KRAUTER, Registrar

Baltimore Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22 19 22.

17 I HEREBY CERTIFY, That I attended deceased from May 13, 19 22 to August 22 19 22.

that I last saw him alive on August 22 19 22.

and that death occurred, on the date stated above, at 1:45 A. M.

The CAUSE OF DEATH* was as follows:

Uremia

CONTRIBUTORY Nephritis, chr. interstitial (Secondary) (duration) yrs. mos. ds. Unknown

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 8-22-22

Was there an autopsy? No Blood Chem. Phenolsulphonophthaleine Mosen- What test confirmed diagnosis? Thal

(Signed) H. J. Lusk, M. D.

Aug 23 19 22 (Address) Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

San Juan Porta Rica

DATE OF BURIAL

Aug 28 19 22

20 UNDERTAKER

Sol Levinson & Bro

ADDRESS

E. Balto St

Exact statement of Occurrence. AGE should be supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

#157981 HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67131

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns. Hopkins Hosp. ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Andie Riscly(a) RESIDENCE NO. 829 S Bond St - City ST. 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos.ds. 7 How long in U. S., if of foreign birth? yes mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofAgnes Henry Riscly6 DATE OF BIRTH (month, day, and year) May 12, 19227 AGE Years 3 Months 14 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland10 NAME OF FATHER Henry Riscly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto.
Maryland12 MAIDEN NAME OF MOTHER Agnes Stinchcomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore
Maryland

14

Informant (Address)

Johns Hopkins Hospital
Registrar

AUG 28 1922

ROBERT H. KRAUTER,

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 192217 I HEREBY CERTIFY, That I attended deceased from Aug 23, 1922 to Aug 27, 1922.that I last saw her alive on Aug 27, 1922, and that death occurred, on the date stated above, at 100 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhea not dysentery(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

HomeDid an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) T B Gay M. D., 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOV.

St. Stanislaus Cem.

DATE OF BURIAL

Aug. 28, 1922

20 UNDERTAKER

M F Sadowski

ADDRESS

705 S. Ann St.

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67132

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 N Paca ST., 17 WARD)2. FULL NAME Mary Elizabeth Cephas(a) RESIDENCE NO. 623 N Paca St ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofBasil Cephas (De)6 DATE OF BIRTH (month, day, and year) Unknown7 AGE 60 Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) 157

(c) Name of employer _____

9 BIRTHPLACE (city or town) Green Ann's Co
(State or country) MD10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) _____12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) _____

14

Informant Nellie E. Hodges
(Address) 623 N Paca St

15

AUG 28 1922

ROBERT H. KRAUTER,

Bureau Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1922

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Aug 26, 1922, that I last saw her alive on Aug 25, 1922,and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

A General debility caused by an arterio sclerosis and senility(duration) _____ yrs. 6 mos. _____ ds.CONTRIBUTORY (Secondary) A Chronic intestinal Catarrh (duration) _____ yrs. 3 mos. _____ ds.

18 Where was disease contracted

If not at place of death? _____

Did an operation precede death? No Date of _____Was there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) Edward J. French, M. D.18 19 MD (Address) 707 Edmond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Ave

20 UNDERTAKER

Chas R A Elliott

DATE OF BURIAL

Aug 28 1922

ADDRESS

1205 2nd St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67133

67133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Presbiterian St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Edward Simpkins(Residence in Baltimore: No. 1520 Presbiterian St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH

December 20, 1884
(Month) (Day) (Year)

7-AGE,

37 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE, (State or Country),

Virginia

10-NAME OF FATHER,

Isaac Simpkins

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Susan Mason

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address)

Obadiah Simpkins1520 Presbiterian St.

15-

AUG 28 1922

ROBERT A. KRAUTER,

Bureau Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 20, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 1922 to Aug 20, 1922that I saw him alive on Aug 20, 1922and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Subarachnoid

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Charles Davis M. D.Aug 20, 1922 (Address) 2108 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Andrew's Cemetery Aug 28, 1922

20-UNDERTAKER ADDRESS

Samuel M. M. M. M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67135

67135

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 E. Laverne ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 417 E. Laverne ST., 12 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) ✓5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) Aug 23 19227 AGE Years Months Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9 BIRTHPLACE (city or town) Baltimore (State or country) md10 NAME OF FATHER Frank Schlosser11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md12 MAIDEN NAME OF MOTHER Ethel P. Thompson13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) md14 Informant Frank Schlosser (Address) 417 E. Laverne15 AUG 26 1922 ROBERT H. KRAUTH Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 192217 I HEREBY CERTIFY, That I attended deceased from Aug 23, 19 22, to Aug 28, 19 22.that I last saw him alive on Aug 27, 19 22.and that death occurred, on the date stated above, at 6-8 m.

The CAUSE OF DEATH* was as follows:

Debility
foremen of male not closed

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Fair M. D., 19 (Address) 12 E. 28th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery Aug 28 1922

20 UNDERTAKER

ADDRESS

Henry W. Means & Son 605 N. Calvert

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 67136

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 67136

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 E. Oliver St., 8 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 40 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Elizabeth Sonderman

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed AUG 28 1922

ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to Aug. 25, 1922.

that I last saw him alive on Aug. 1, 1922.

and that death occurred, on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Acute Dilation of Stent.
Chronic Endocarditis & Myocarditis.
(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 67137 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67137

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Josephs Hospital* ST.; *9* WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2002 Robt* St.; *15* yrs., *1* mos., *15* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Feb 16, 1858
(Month) (Day) (Year)

7-AGE,

64 yrs., *1* mos., *15* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....*At Home*

9-BIRTHPLACE,

(State or Country) *Harford Co Md*

10-NAME OF FATHER,

? Bagley

11-BIRTHPLACE OF FATHER

(State or Country), *Md.*

12-MAIDEN NAME OF MOTHER

? Husband

13-BIRTHPLACE OF MOTHER

(State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank B. Foard*(Address) *Stemmers Ave Md*

15-

AUG 28 1922

ROBERT H. KRAUTER,

Bureau of Vital Statistics, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 27, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 12, 1922, to Aug 27, 1922,*that I saw him alive on *Aug 27, 1922,*and that death occurred, on the date stated above, at *2:30 a.m.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

Cholera (Duration).....yrs.....mos.....ds.(Signed) *Harold C. Pillsbury, M. D.**Aug 27, 1922* (Address) *St. Josephs Hospital*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *1* yrs., *1* mos., *13* ds. In the *15* yrs., *1* mos., *15* ds.

Where was disease contracted, if not at place of death?

Former or usual residence *2002 Robt Street*

19-PLACE OF BURIAL OR REMOVAL,

Wood Chapel

DATE OF BURIAL,

Aug 29, 1922

20-UNDERTAKER

Wm Cook

ADDRESS

502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67138

CERTIFICATE OF DEATH.

REGISTERED NO. C.

90 D 67138

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Notre Dame of Maryland* ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Charles Street Ave.* St.; *40* yrs.; *0* mos.; *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

*White*5-SINGLE, *single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH.

December 23rd, 1844
(Month) (Day) (Year)

7-AGE.

77 yrs.; *8* mos.; *0* ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*At home*9-BIRTHPLACE,
(State or Country).*New Brunswick, Canada*

10-NAME OF FATHER,

*Cornelius Launey*11-BIRTHPLACE OF FATHER
(State or Country).*Ireland*

12-MAIDEN NAME OF MOTHER

*Martha Murray*13-BIRTHPLACE OF MOTHER
(State or Country).*Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Sister M. Philemon*(Address) *Charles Street Ave.*

AUG 28 1922

ROBERT H. RAUTER,

Filed

191

Bural. Permit. Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 26, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Aug 1, 1922*, to *Aug 26, 1922*that I am *alive* on *Aug 25, 1922*and that death occurred, on the date stated above, at *0* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema(Duration) *0* yrs. *0* mos. *0* ds.CONTRIBUTORY
(Secondary)*Myocardial*
(Duration) *0* yrs. *0* mos. *0* ds.(Signed) *Charles J. ...**8/29, 1922*(Address) *702 ...*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Gowanstown Private Burial

20-UNDERTAKER

Frank A. Pink

DATE OF BURIAL,

Aug 29, 1922

ADDRESS

915 N. Gay St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION, if any, important. See instructions on back of certificate.

D 67139

HEALTH DEPARTMENT—CITY OF BALTIMORE

67139

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Bay View Hospital

CITY OF BALTIMORE: (No.

Eastern Ave. ST.

WARD)

2-FULL NAME

Katherine Mueller

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

634. S. Curley

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1907

7 AGE

15

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sales Lady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balti. Md.

14

Informant (Address)

Hospital Records

15

28 1922

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25 1922

17

I HEREBY CERTIFY, That I attended deceased from

5-10 1922 to 8-25 1922.

that I last saw her alive on 8-25 1922.

and that death occurred, on the date stated above, at 5.15 a.m.

The CAUSE OF DEATH* was as follows:

Cerebellar Tumor.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 1922

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Richardson M. D.

19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

DATE OF BURIAL

Immanuel Cemetery Aug 29 1922

20 UNDERTAKER

ADDRESS

Geo M. Fink & Son 811 N Wolfe

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67140

CERTIFICATE OF DEATH.

D 67140

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *24* WARD)

2-FULL NAME

(a) RESIDENCE NO. *1119 Riverside Ave.* ST. *1* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *3* yrs. *3* mos. *3* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 26* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *July 17*, 19 *22*, to *Aug 26*, 19 *22*, that I last saw him alive on *Aug 26*, 19 *22*, and that death occurred, on the date stated above, at *11 a* m.

The CAUSE OF DEATH* was as follows:

Childbirth.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No.* Date of *10.*Was there an autopsy? *No.*What test confirmed diagnosis? *Sig. & Signs & Lab.*

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

2281922 Burial Permit Clerk

D 67141

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mike Smith(a) RESIDENCE No. 1600 Harford Ave.ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18557 AGE Years Months Days If LESS than 1 day, hrs. or min.
67 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Andrew Smith11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Mary Jefferson13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14

Informant
(Address)Hospital Records, Municipal Hospital.

15

Informant
(Address)Robert P. Harrison

2/8 1922

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1922

17

I HEREBY CERTIFY, That I attended deceased from August 21, 1922, to August 24, 1922.that I last saw him alive on August 23, 1922.and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
(duration) yrs. 1 mos. 1 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. M. Hall, M. D.8/24/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health,

ADDRESS

19Disinterred Aug 30. Buried at Maple Grove Cemetery

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67142

CERTIFICATE OF DEATH.

REGISTERED NO.

D 67142

1-PLACE OF DEATH

Municipal Hosp.

ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO)

2-FULL NAME

George Holt

(a) RESIDENCE. NO.

Baltimore

(Usual place of abode)
Length of residence in city or town where death occurred

mos.

ds.

ST.: WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed,
or Divorced (write the word)

1

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7-10-53

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Bookkeeper

(b) General nature of industry,
business, or establishment in
which employed (or employer)

011

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Md

10 NAME OF FATHER

Joseph Holt

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Sarah Holt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore

14

Informant
(Address)

Hosp. Records

15

Robert P. Harrison,

19

Registrar

20 UNDERTAKER

J. G. Moran

State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Greenmount Cemetery

DATE OF BURIAL

8-29-1922

ADDRESS 3000

E. B. Eaton

16 DATE OF DEATH (month, day, and year)

Aug. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from

10-2-1920, to 8-26-1922

that I last saw him alive on 8-26-1922

and that death occurred, on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Saut

CONTRIBUTORY
(Secondary)

(duration)

5 yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Baltimore

Did an operation precede death?

NO

Was there an autopsy?

NO

What test confirmed diagnosis?

Munich-Munich

(Signed)

Clyde McNeill

M. D.

1922 Address

Munich Hosp.

G 2 8 1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67143

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital* ST., *19* WARD)

2-FULL NAME

Baby Ostman(a) RESIDENCE NO. *1832 Wilkins Ave* ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female white single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*none*6 DATE OF BIRTH (month, day, and year) *Aug 28, 1922*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Woman's Hospital

10 NAME OF FATHER

Samuel Ostman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Sarah Berman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Hospital Records

15

Filed *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 28 1922*17 I HEREBY CERTIFY, That I attended deceased from 19 to *Aug. 27 1922*that I last saw her alive on *Aug. 28 1922*and that death occurred, on the date stated above, at *6³⁰ A.M.*

The CAUSE OF DEATH* was as follows:

Prematurity (about 6 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *yes*

What test confirmed diagnosis?

(Signed)

J. F. Hoff

M. D.

19

(Address)

Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Funeral Home

DATE OF BURIAL

Aug 28 1922

ADDRESS

20 UNDERTAKER

*Jack Lewis**1432 E. Bala*Exact statement of OCCUR-
rence should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

28 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67144

CERTIFICATE OF DEATH.

D 67144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 N Bethel ST., 8 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1824 N Bethel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE Widow of John H. Luft6 DATE OF BIRTH (month, day, and year) Dec 2/18457 AGE Years 76 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

Filed

Reb. 19 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 19 2217 I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to Aug 27, 1922, that I last saw her alive on Aug 26, 1922, and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Lewis, M. D. 8/27/22 (Address) 415 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

281322

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67145

D 67145

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

ST. 18

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lloyd E. Russell

(a) RESIDENCE.

813 1/2 W. Fayette St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 3 mos.

X ✓ ds.

How long in U. S., if of foreign birth?

yrs

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 11 - 1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

1

3

XX

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore, Md

10 NAME OF FATHER

Lloyd Russell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Ester Fitzhugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Chicago, Ill.

14

Informant
(Address)

Hospital Records

15

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 25 1922

17

I HEREBY CERTIFY, That I attended deceased from
July 22, 1922, to Aug 25, 1922,
that I last saw him alive on Aug 25, 1922,

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Entire Intoxication

(duration) XX yrs. 2 mos. 22 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

at home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Trinity Cemetery

Aug 28 1922

20 UNDERTAKER

ADDRESS

James E. Towson

12-14 N. Green St

Information should be carefully supplied. Exact statement of OCCUR-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

G 281922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67146

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2909 Riggs ST. 16 WARD)

2-FULL NAME

Milton B. Weston

(a) RESIDENCE NO.

2909 Riggs

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

42 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 ~~Single~~, Married, Widowed,
or Divorced, (write the word)Male WhiteMarried5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofBessie L. Weston

6 DATE OF BIRTH (month, day, and year)

Feb 4 1862

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.60823

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workShip Smith(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Mathews, Co
Virginia

10 NAME OF FATHER

John Weston

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Lucille Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant

(Address)

Mrs Bessie L. Weston
2909 Riggs av

15

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

AUG 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 26 1922 to Aug 27, 19 22

that I last saw him alive on

Aug 27, 19 22and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of ✓Was there an autopsy? No

What test confirmed diagnosis?

Chemical signs

(Signed)

M. D.

M. D.

AUG 28 1922

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVALLondon Park

DATE OF BURIAL

AUG 30 1922

20 UNDERTAKER

Geo W Little

ADDRESS

2900
HOMERSON AVE

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 28 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Songwood ST.; 16 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1132 Songwood St.; 37 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

December 7, 1884
(Month) (Day) (Year)

7-AGE,

37 yrs. 8 mos. 20 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Clerk 109
Gas Co

9-BIRTHPLACE, (State or Country),

Baltimore Md

10-NAME OF FATHER,

Charles W Johnson

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Fannie F. Murphy

13-BIRTHPLACE OF MOTHER (State or Country),

Howard Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth E. Johnson(Address) 1132 Songwood St

15-

Robert P. Harrison,

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 27, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug. 1 - 1922, to Aug 27 - 1922, that I saw him alive on Aug. 27, 1922, and that death occurred, on the date stated above, at 6:40 p. m.

The CAUSE OF DEATH* was as follows:

Paratyphoid fever (probably) (10-12 days)
Double Lobar Pneumonia
about 23 hrs
(Duration) yrs. mos. ds.
Toxemia
CONTRIBUTORY Repeated chills, prostration
(Secondary) Cerebral meningitis (not well defined)
(Duration) yrs. mos. ds.
3 or 4 days(Signed) Carlton M. Cook M. D.
Aug 28, 1922 (Address) 1107 W. Laurel St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St O Live

DATE OF BURIAL,

Aug 30, 1922

20-UNDERTAKER

Geo W Little

ADDRESS

2700
EDMONSON AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

AUG 27 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67148

CERTIFICATE OF DEATH.

D 67148

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

438 N. Fremont ST.: 18

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Wilhelmina Reilly

(a) RESIDENCE. No.

438 N. Fremont ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

79 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chas Reilly

6 DATE OF BIRTH (month, day, and year)

Aug 3/1843

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

79

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home.

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto md.

10 NAME OF FATHER

Wm. Seyborn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland Europe

12 MAIDEN NAME OF MOTHER

Mary Buit

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland Europe

14

Informant

(Address)

Chas. Reilly 1104 N. Stricker

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 15, 1922, to Aug 27, 1922,

that I last saw her alive on Aug 27, 1922,

and that death occurred, on the date stated above, at 7:45 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Geo W. Hemminger, M. D.

8-28-1922

(Address)

800 Harbison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Balto md. Wm. Cook

Aug 31 1922 502 E. N. H. H.

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

281922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Chronic Bright's Disease

D 67149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Bombardier ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 2120 Bombardier ST.: 1 WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds.How long in U. S. if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles Dabry6 DATE OF BIRTH (month, day, and year) Aug 1908

7 AGE

63

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bohemia

10 NAME OF FATHER

Frank Dabry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Ann Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

14

Informant (Address)

Charles Dabry
2120 Bombardier St

15

Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 25, 1922, to Aug 26, 1922,that I last saw him alive on Aug 26, 1922,and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

2281922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67150

CERTIFICATE OF DEATH.

67150

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

47 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 47 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

AUG 29 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

ST. 23 WARD)

ST. WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 26 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 24 1922 to Aug 26 1922

that I last saw her alive on Aug 25 1922

and that death occurred, on the date stated above, at 8.15 a m.

The CAUSE OF DEATH* was as follows:

Diabetes.

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem Aug 29 1922

20 UNDERTAKER

ADDRESS 1037

E. Schloman & Son Hanover

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

67151

HEALTH DEPARTMENT—CITY OF BALTIMORE

67151

CERTIFICATE OF DEATH.

38

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Wd. Gen. Hosp. 25* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Harry E. Zimmerman*

(Residence in Baltimore: No. *Maple & Hickory Ave. 48* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH, *Dec. 11, 1893* (Month) (Day) (Year)

7-AGE, *28* yrs. *8* mos. *15* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Steel worker* (b) General nature of industry, business, or establishment in which employed (or employer). *Wayne Docks*

9-BIRTHPLACE, (State or Country). *Balto. Md.*

PARENTS.

10-NAME OF FATHER. *Wm. T. Zimmerman*

11-BIRTHPLACE OF FATHER, (State or Country). *Md.*

12-MAIDEN NAME OF MOTHER. *Julius Gent*

13-BIRTHPLACE OF MOTHER, (State or Country). *Md.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug. 26, 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *autopsy* (Inquest, autopsy or inquest.) thereon and from the evidence obtained by said *autopsy* (Inquest, au- topsy or inquest.) and that said deceased came to *his* death on the day *Aug. 26* stated above. The CAUSE OF DEATH* was as follows: *Syphilis (General)* *over 1 yr.* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) *J. T. Heumesser* M. D. (Coroner.) *Aug. 26, 1922* (Address) *2802 Edgemoor Ave.*

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents) At place *Wd. Gen. Hosp.* In the of death. yrs. mos. *11* ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death? *Bethel Steel Co., (Baltimore, Md.)*

Former or usual residence. *Maple & Hickory Ave.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *London Park Cem Aug 30, 1922*

20-UNDERTAKER, ADDRESS *E. Scholman & Son, Fanora St.*

15- AUG 29 1922

ROBERT R. KRAUTER, Death Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67152

CERTIFICATE OF DEATH.

31

D 67152

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 N. Eden St. ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Eliza Standford

(a) RESIDENCE No.

105 N. Eden St.

ST.

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

unknown

6 DATE OF BIRTH (month, day, and year)

1889

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

33

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

—

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Alex Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Eliza Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Ethel Fountain, 105 N. Eden St.

15

AUG 29 1922

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

August 26 22

17

I HEREBY CERTIFY, That I attended deceased from August 18, 1922, to August 26, 1922, that I last saw her alive on August 26, 1922, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs
Tuberculosis of Lungs
(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Lungs (duration) yrs. 4 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. W. H. Marshall, M. D.

8-26-22 Address 708 Ensor St.

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING Ashbury Cem. Aug 29 1922

20 UNDERTAKER

Chris. H. Johnson 416 St. N. Caroline St.

Anna Catherine Homborg
HEALTH DEPARTMENT—CITY OF BALTIMORE
D 67153 45 D 67153

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. German Aged Home St. 20 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Anna Catherine Homborg

(Residence in Baltimore: No. German Aged Home St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

6-DATE OF BIRTH, June 16th, 1 1922
(Month) (Day) (Year)

7-AGE, 76 yrs. 2 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer), None

9-BIRTHPLACE, (State or Country), Germany

PARENTS.
10-NAME OF FATHER, Henry Inlauf
11-BIRTHPLACE OF FATHER, (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Unknown
13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) German Aged Home Records

(Address) Baltimore & Payson Sts.

15- AUG 29 1922 ROBERT A. KRAUTER,
Filed 1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 26th, 192 2
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, and that said deceased came to her death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma of Ab Intestines

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) James M. Brewster M. D. (Coroner.)
8/29 192 2 (Address) 1003 N. Dallas St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Oaklawn Cemetery Aug. 29, 1922

20-UNDERTAKER, ADDRESS

Joseph B. Cook 1063 N. Dallas St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67154

D 67154

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 N. Ellwood Ave. ST., 6 WARD)

2. FULL NAME

Albertina Tews

(a) RESIDENCE NO.

19 N. Ellwood Ave.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofAlbert Tews6 DATE OF BIRTH (month, day, and year) May 5" 1861

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.61322

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Mr. Klavitter

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Miss Abendstern

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)Gertrude T. Cole19 N. Ellwood Ave.

15

AUG 29 1922ROBERT H. KRAUTER,Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from

June 19 19 22, to August 27 19 22,that I last saw him alive on Aug 27 19 22,and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency following a prolonged attack of bronchial asthma

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Bronchial asthma

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Original Study
Harry W. Stein, M. D.

8/28/22 (Address)

1315 Mt. Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Louisa Park Cemetery Aug 30 19 22Joseph B. Cook 1003 N. Baltimore

67155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 67155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Municipal Pvc Hosp* ST. *49* WARD)2-FULL NAME *Alice Butler*(a) RESIDENCE NO. *216 N. Bethel* ST. *49* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

7 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Col.* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Domestic

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Hosp. Records

15

Filed

AUG 29 1922

ROBERT R. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 25 1922*17 I HEREBY CERTIFY, That I attended deceased from *Aug 24 1922* to *Aug 25 1922* that I last saw her alive on *Aug 25 1922* and that death occurred, on the date stated above, at *6 55 p.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Pvc.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

*Aug 29 1922*ADDRESS *1671**Arloona*

Exact statement of OCCURRENCE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67156

131 D 67156

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Albert Harris

(a) RESIDENCE NO.

UnknownST. 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1862

7 AGE

60

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hospital Records, Municipal Hospital.

15

AUG 29 1922ROBERT R. KRAUTER,Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 19 2217 I HEREBY CERTIFY, That I attended deceased from August 26, 19 22 to August 27, 19 22, that I last saw him alive on August 26, 19 22, and that death occurred, on the date stated above, at 5:30 A.M. The CAUSE OF DEATH* was as follows:Pylonephritis

CONTRIBUTORY (Secondary)

Renal insufficiency

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 26 1922Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeil, M. D.8/28/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Auburn Cemetery

20 UNDERTAKER

Eduard Bryan

DATE OF BURIAL

30 Aug 1922

ADDRESS

671 Orleans

Exact statement of occurrence should be carefully supplied. Note—Cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1615 W Lexington St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1615 W Lexington St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <u>male</u>	4-COLOR OR RACE, <u>Colored</u>	5-Single, Married, Widowed, or Divorced. <u>Single</u> (Write the word.)
6-DATE OF BIRTH, <u>Aug</u> <u>21</u> <u>1921</u> (Month) (Day) (Year)		
7-AGE,yrs.....mos.....ds. <u>7</u>		If LESS than 1 day,hrs. or.....min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer).....		

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sophie Burrell
(Address) 1615 W Lexington

15-

File

AUG 29 1922

ROBERT R. KRAUTER,
Bureau Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 27 1921
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said Inquest, find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.
(Signed) James M. Fenton M. D.
(Coroner.)
Aug 28 1921 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL,

Mr. Dennis

20-UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 FRESTMAN ST.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67158

D 67158

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Woman's Hospital
Baby Brooks.

ST. 27 WARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

(a) RESIDENCE NO.

Mt. Washington

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced, (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 26, 1922

7 AGE

Years

Months

Days

If LESS than
1 day, 2 hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Nurse

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

Henry Phelps Brooks

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Eveline Boggs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Tennessee

14

Informant
(Address)Henry Phelps Brooks
Mt. Washington

Robert P. [unclear]

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 26, 1922, to Aug 27, 1922,

that I last saw him alive on Aug 27, 1922

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(about 4 months pregnancy)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. F. Goff M. D.

19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

JOHN HOPKINS HOSPITAL

DATE OF BURIAL

19

20 UNDERTAKER

Commissioner Health

ADDRESS

AUG 28 1922

Information should be carefully supplied. Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67159

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Mallory ST. 15 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

80 yrs. 11 mos. 8 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

AUG 29 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1922, to Aug 27, 1922, that I last saw her alive on Aug 27, 1922, and that death occurred, on the date stated above, at 10 p. m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) X yrs. X mos. 7 ds.

CONTRIBUTORY (Secondary)

myocardial

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

157763 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST. *71* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Flynn

(a) RESIDENCE NO.

1139 S. Paca St. City

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced

HUSBAND of
*(or) WIFE of**Mary & John Flynn Parents*6 DATE OF BIRTH (month, day, and year) *Sept. 1, 1921*

7 AGE

Years

Months

Days

If LESS than
1 day, ... hrs.
or min.*11**28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

*John Flynn*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balto.*
Maryland

12 MAIDEN NAME OF MOTHER

*Mary Sabatino*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto.*
Maryland

14

Informant
(Address)*Johns Hopkins Hosp. Records*

15

AUG 29 1922

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 28 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Aug 13 1922 to Aug 28 1922.*That I last saw him alive on *Aug 28 1922.*and that death occurred, on the date stated above, at *10:00 A.M.*

The CAUSE OF DEATH* was as follows:

*Diarrhoea (not dysentery)**Dysentery (Typhoid)*(duration) yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)*Diarrhoea*
(duration) yrs. *1 1/2* mos. ds.18 Where was disease contracted
if not at place of death?*at home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Horton Casparian*, M. D., 19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

London Park Cemetery *Aug 30 1922*

20 UNDERTAKER

ADDRESS

James Dignam & Son *1000 S. Paca*

mation should be carefully supplied. Exact statement of OCCASION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67161

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-803D 67161

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *12* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *3 York Court, (Gulfport)* St.; yrs. *5* mos. *9* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

*White*5-Single, Married, Widowed, or Divorced, (Write the word.) *single*

6-DATE OF BIRTH,

*March 18,**1920*

(Month)

(Day)

(Year)

7-AGE,

22 yrs. *5* mos. *9* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

Insurance Solicitor
Mexco. Life Ins. Co.

9-BIRTHPLACE, (State or Country).

Balto. Md.

10-NAME OF FATHER,

Samuel W. Tratt

11-BIRTHPLACE OF FATHER, (State or Country).

Balto. Md.

12-MAIDEN NAME OF MOTHER,

Emma J. M. Curry

13-BIRTHPLACE OF MOTHER, (State or Country).

Wash. D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Samuel W. Tratt

(Address),

3 York Court, (Gulfport)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*August 27,**1922*

(Month)

(Day)

(Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Fracture of skull (base)*CONTRIBUTORY *automobile accident* (Secondary)(Signed) *J. T. Neumeyer* (Coroner)Aug. 28, 1922 (Address) *2802 Edmondson Ave.*

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place *md. Gen. Hosp* on the of death. *md.* yrs. *5* mos. *9* ds. State. *md.* yrs. *5* mos. *9* ds.

Where was disease contracted, if not at place of death?

*Reidsburg, Pa.*Former or usual residence *3 York Court*

PLACE OF BURIAL OR REMOVAL,

Loudon Park Cemetery

20-UNDERTAKER,

*Henry W. Mears & Son**805 N. Calvert*

AUG 29 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67162

D 67162

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins* St. *6* Ward)2-FULL NAME *Raymond J. Bosley*(Residence in Baltimore: No. *20 N. Port* St.; yrs. mos. ds.)

CERTIFICATE OF DEATH.

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE, *White*5-*Single*,
Married,
Widowed,
Of divorced
(Write the word.)6-DATE OF BIRTH, *Nov 5 1883*

(Month)

(Day)

(Year)

7-AGE, *28* yrs. *9* mos. *22* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Foreman*(b) General nature of industry, business, or establishment in which employed (or employer), *City Highway*9-BIRTHPLACE, (State or Country), *Balto*

PARENTS.

10-NAME OF FATHER, *Samuel James Bosley*11-BIRTHPLACE OF FATHER, (State or Country), *Balto Co Md*12-MAIDEN NAME OF MOTHER, *Alice Mueller*13-BIRTHPLACE OF MOTHER, (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Anna Veltman*(Address) *20 N. Port*

AUG 29 1922

ROBERT N. KRAUTER,

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 27 1922*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest, au-**inquiry* and that said deceased came to *death*

(topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident at Beach, Automobile
overturned in which he was
injured, caused by blood out
of him. (Duration) yrs. mos. ds.(Secondary) *Prodigious Skull Fracture*

(Duration) yrs. mos. ds.

(Signed) *J. D. Miller*

(Coroner)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *New Cathedral*DATE OF BURIAL, *Aug 30 1922*20-UNDERTAKER, *John Mueller*ADDRESS, *1803 Bank*

D 67163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67163

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1625 Jackson St. St. 24 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

Cechial M. Muller.

25 --- 9 --- 4.

(Residence in Baltimore: No. 1625 Jackson St. St.; yrs. --- mos. --- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female.

4-COLOR OR RACE,

White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH,

November 23, 1896.

(Month)

(Day)

(Year)

7-AGE,

25 yrs. 9 mos. 4 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country).

Baltimore Md.

10-NAME OF FATHER,

Charles T. Mc Cleary.

11-BIRTHPLACE OF FATHER,

(State or Country).

Washington Co. Md.

12-MAIDEN NAME OF MOTHER,

Ethel Mc Kee.

13-BIRTHPLACE OF MOTHER,

(State or Country).

Missouri.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Max Wm Muller. (husband).

(Address) 1625 Jackson St.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

August 27, 1922.

(Month)

(Day)

1922 (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism.

(Duration) yrs. mos. ds.

CONTRIBUTORY Abortion. Non criminal.

(Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.

(Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Linden Park

8/29/1922

20-UNDERTAKER,

ADDRESS

Edw J. Fanning 1260 Battery Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

AUG 29 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67164

CERTIFICATE OF DEATH.

D 67164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Sydenham Hospital* ST. *76* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *George Lang*(a) RESIDENCE. NO. *Vale, Md (Harford Co.)* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct 18 - 1921*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*0**10**11**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore
Md*10 NAME OF FATHER *George Lang*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Balto
Md*12 MAIDEN NAME OF MOTHER *Elsie Hopkins*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Balto
Md*

14

Informant
(Address)*George Lang
Vale, Md Harford Co*

15

Filed

AUG 29 1922

ROBERT A. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 28* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Aug 20, 19 *22*, to *Aug 28*, 19 *22*,that I last saw him alive on *Aug 28*, 19 *22*,and that death occurred, on the date stated above, at *8:45 A* m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria(duration) — yrs. — mos. *12* ds.CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted
if not at place of death? *at home*Did an operation precede death? *no* Date of —

Was there an autopsy? —

What test confirmed diagnosis? *Culture positive*(Signed) *B. Magowan*, M. D.8/29/22 (Address) *Sydenham Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*London Park**8/29* 19 *22*

20 UNDERTAKER

ADDRESS

Martin Hakey & Sons 1827 W. North

CERTIFICATE OF DEATH.

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 262 Bower ST. 11 WARD

(Usual place of abode) 68 yrs. mos. ds. (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19/22

17 I HEREBY CERTIFY, That I attended deceased from
September 19 *20* to *Aug. 29* 19 *22*.

that I last saw him alive on Aug 28, 1922.

and that death occurred on the date stated above at 1:30 a.

The CAUSE OF DEATH* was as follows:

None.

None.

None.

md.

Herd.

(city or town) German

Mattie Fender

(city or town)

15
File **AUG 29 1922** **ROBERT H. KRAHN**

Chronic interstitial nephritis

(duration) about 2 yrs. — mos — ds

CONTRIBUTORY
(Secondary)

(duration) yrs. 2 mos. ds

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? *Urinalyses, etc.*

(Signed) W. J. Hoffmann M. D.

, 19 (Address) 2100 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE.

DATE OF BURIAL

MOYAL
Hebrew Friends
UNDERTAKER

8/31/1922

70 UNDERTAKER
David Sondheim

ADDRESS
118 W. 1st St.
Royal Pk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67166

D 67166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1340 N. Mount St.

ST.

15

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Berthenia Carroll

(a) RESIDENCE. NO.

1340 N. Mount St.

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5-7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Ella Warfield
1406 N. Bond St.

15

filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26 1922

17

I HEREBY CERTIFY, That I attended deceased from 8-22-1922, to 8-26-1922,

that I last saw her alive on 8-26-1922, and that death occurred, on the date stated above, at 11:05 A.M.

The CAUSE OF DEATH* was as follows:

Paraplegia

(duration)

yrs.

mos.

26 ds.

CONTRIBUTORY (Secondary)

Trauma (Fall) about 2

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

(over)

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed)

George C. Page

M. D.

19

(Address)

1700 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

JAMES H. DENNIS

ADDRESS

Mad 1014

1303 PRESTMAN ST.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

O. K. by
J. T. Hemmery M.D.
Coroner of N. W. Dist.
Accidental Fall against
store in Killeen

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67167

CERTIFICATE OF DEATH.

D 67167

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables

ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel McGill

(a) RESIDENCE. NO. 1129 N. Calvert

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

female white single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sep. 8. 1847

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

74 11 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dr. T. B. Fitcher

9 BIRTHPLACE (city or town) Ireland (State or country)

10 NAME OF FATHER Thomas McGill

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Bridget A. Flynn

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Dr. Thomas B. Fitcher (Address) 1129 N. Calvert

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28. 1922

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1921, to Aug 27, 1922, that I last saw her alive on Aug 27, 1922, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

CONTRIBUTORY (duration) ? yrs. mos. ds. Fracture shaft of femur about 4 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Sellers & Heat

(Signed) W. S. Mayo, M. D.

, 19 (Address) Catrobe Apartment

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenmount Cemetery

Aug 30-22

20 UNDERTAKER

ADDRESS

H. E. Hughes

424 N. Brady.

29 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67168

CERTIFICATE OF DEATH.

D 67168

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1366 Reynolds ST., 24 WARD)

2-FULL NAME

Walter Pugaczewski

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1366 Reynolds ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3mos. 14

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 14-22

7 AGE

Years

Months

Days

If LESS than 1 day...hrs or...min.

314

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

"

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Michael Pugaczewski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Leokadia Ludwicz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Michael Pugaczewski
1366 Reynolds

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-28 1922

17

I HEREBY CERTIFY, That I attended deceased from

8-22, 1922, to 8-28, 1922that I last saw him alive on 8-28, 1922and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (cerebral)

(duration)

yrs.

mos. 3

ds.

CONTRIBUTORY (Secondary)

Diarrhea & enteritis

(duration)

yrs.

mos. 8

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? usual tests

(Signed)

S. P. P. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

DATE OF BURIAL

TORY

Holy Rosary,Aug 30 1922

10 UNDER TAKER

W. J. Fialkowski

ADDRESS

118 Eastern
av

Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

29 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67169

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 508 So. Bond St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 508 So. Bond St. 3 Ward)35 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced. Widow
(Write the word.)6-DATE OF BIRTH, Unknown
(Month) (Day) (Year)7-AGE, about 35 yrs., 0 mos., 0 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housework
(b) General nature of industry, business, or establishment in which employed (or employer) do9-BIRTHPLACE, (State or Country), Russia, Poland10-NAME OF FATHER, Unknown11-BIRTHPLACE OF FATHER, (State or Country), Unknown12-MAIDEN NAME OF MOTHER, Unknown13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helixa Lisiecki(Address) 508 So. Bond St15- Robert P. Harrison Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 27 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:Heart Failure
arose
(Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) old age
(Duration) yrs. mos. ds.
(Signed) Thos B. Harrison M. D.
(Coroner) Aug 29 1922 (Address) 1000 Bay*State the Disease Causing Death, or, if death from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. no18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, Aug 30 1922UNDER-TAKER, William Hall ADDRESS, 1618 Eastern

N.B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

D 67170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Harry H. Hanill.63(Residence in Baltimore: No. 1437 N. Charles St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Single
(Write the word.)6-DATE OF BIRTH, Do not know. 1 86
(Month) (Day) (Year)7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Attorney at Law.
(b) General nature of industry, business, or establishment in which employed (or employer), 429-BIRTHPLACE, (State or Country), Baltimore, Md.10-NAME OF FATHER, John W. Hanill.11-BIRTHPLACE OF FATHER, (State or Country), Maryland.12-MAIDEN NAME OF MOTHER, Sylvia C. Hunt.13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Ferdinand C. Dugan.(Address), 111 N. Charles St.

15-

Filed, Robert P. Harrison, Registrar.

29 1922

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 23th. 1922. 192....
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aboblexu.
Cardiac Failure.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signature) Otto M. Reinhardt M. D.
(Coroner.)Aug. 23 1922 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.Where was disease contracted, if not at place of death?
1437 N. Charles St. August 23th. 1922

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Green Mount Aug 30, 1922

20-UNDERTAKER. ADDRESS

Martin F. Hays, 1827 W. North Ave

D 67171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67171

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Harlem ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 1606 Harlem ST., 16 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Louis Fowler6 DATE OF BIRTH (month, day, and year) May 9, 18557 AGE 69 Years 3 Months 19 Days If LESS than 1 day, — hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman(b) General nature of industry, business, or establishment in which employed (or employer) 086(c) Name of employer Henry A. Hillman9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.10 NAME OF FATHER Julius Fowler11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.12 MAIDEN NAME OF MOTHER Anna C. Hillman13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.14 Informant Julius Louis Fowler (Address) 1606 Harlem St.15 Robert L. Hillman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 192217 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to Aug 28, 1922,that I last saw him alive on Aug 28, 1922,and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph J. Herling M. D.19 (Address) Walt. 1501 V. Blvd. B2

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL GraveyardDATE OF BURIAL Aug 31 192220 UNDERTAKER H. HillmanADDRESS 1606 Harlem St.

Exact statement of OCCASION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

29 1922

Burial Permit Clerk.

157120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67172

CERTIFICATE OF DEATH.

D 67172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp.* ST., *15* WARD)

2-FULL NAME

Joseph Klaval

(a) RESIDENCE NO.

1310 Stricker St. City

(Usual place of abode)

Length of residence in city or town where death occurred

Life.

yrs. mos. ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single.

5a If married, widowed, or divorced

(1) *Widowed**Eleanor Klaval (mother)*

6 DATE OF BIRTH (month, day, and year)

Jan 1, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Joseph Klaval

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Eleanor Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Johns Hopkins Hosp. Records

15

ROBERT H. KRAUTER,

Burial Permit Clerk

AUG 30 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

*July 18, 1922, to Aug 27, 1922.*that I last saw him alive on *Aug 27, 1922.*and that death occurred, on the date stated above, at *11:00 P. m.*

The CAUSE OF DEATH* was as follows:

Pertussis(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Horton Casparis*, M. D.19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

ST Peters Cemetery Aug 30 1922

20 UNDERTAKER

ADDRESS

Edward Ringgold 1403 Carey

Information should be carefully supplied. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 253 S. Dallas

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME JOHN M. MILLER,

(a) RESIDENCE No. 253 S. Dallas

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred I yrs. I mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male, White, Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2-1921.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
I I 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md., (State or country)

10 NAME OF FATHER John Miller,

11 BIRTHPLACE OF FATHER (city or town) Poland, (State or country)

12 MAIDEN NAME OF MOTHER Mary Rajtaczak,

13 BIRTHPLACE OF MOTHER (city or town) Billox, Miss, (State or country)

14 Informant Mrs. Mary Miller, (Address) # 253 S. Dallas Street

15 AUG 30 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 24/8/ 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug 15- 19 22 to Aug 29 19 22, that I last saw him alive on Aug 28 19 22, and that death occurred, on the date stated above, at 3 p m. The CAUSE OF DEATH* was as follows:
Gastro-Enteritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 14 ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) J. P. Bruns, M. D.

, 19 (Address) 125 S. Orleans

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus Cem. Aug 30. 1922

20 UNDERTAKER

ADDRESS

M. J. Sadowski 405 S. Ann

Information should be carefully supplied. For more information, see instructions on back of certificates. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67174

CERTIFICATE OF DEATH.

113 D 67174
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1147 Whatcoat ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marion Green(Residence in Baltimore: No. 1147 Whatcoat St.; 2 yrs., 2 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. Color 5-SINGLE, Single MARRIED, WIDOWED, OR DIVORCED. (Write the word.)6-DATE OF BIRTH. June 28, 1922
(Month) (Day) (Year)7-AGE. 2 yrs., 2 mos., 2 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE.
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Eva Green(Address) 1147 Whatcoat St.15- AUG 30 1922 ROBERT K. KRAUTERFiled 191 Bureau Permit Clark

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug. 28th, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 28 1922 to Aug 28 1922 that I saw him alive on Aug 28 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
(Duration) 1 yrs., 1 mos., 2 ds.CONTRIBUTORY
(Secondary)(Signed) Robert J. Kirk M. D. (Duration) 1 yrs., 1 mos., 2 ds.
Aug 29 1922 (Address) 3126 Bayview Ave

*State the DISEASE CAUSING DEATH, or, in death from violent causes, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs., 1 mos., 2 ds. In the State 1 yrs., 1 mos., 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

My Cousin Aug 28, 192220-UNDERTAKER Sam Epton ADDRESS 916

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67175

CERTIFICATE OF DEATH.

113 D 67175

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *165 Orchard* ST.; *17* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *165 Orchard* St.; *3* yrs., *3* mos., *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Caucas

5-SINGLE

Single
MARRIED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

May 8th, 19*22*
(Month) (Day) (Year)

7-AGE.

3 yrs., *20* mos., *3* ds.If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country),*md.*

10-NAME OF FATHER.

*Howard Henry King*11-BIRTHPLACE OF FATHER
(State or Country),*md.*

12-MAIDEN NAME OF MOTHER

*Henry Dyer Duffin*13-BIRTHPLACE OF MOTHER
(State or Country),*Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

AUG 30 1922

Filed

101. ROBERT M. KRAUTER,

Registrar.
Burial Permit Blank.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Aug. 28th, 19*22*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Aug 27th 19*22* to *Aug 28th* 19*22*that I saw her alive on *Aug 27th* 19*22*and that death occurred, on the date stated above, at *10 A.M.*

The CAUSE OF DEATH* was as follows:

Fatal - unknown(Duration) *1* yrs., *1* mos., *3* ds.CONTRIBUTORY
(Secondary)(Duration) *1* yrs., *1* mos., *3* ds.(Signed) *A. L. King* M. D.*875*, 10*th* (Address) *924 Madison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs., *20* mos., *3* ds. In the State *3* yrs., *3* mos., *3* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

MT Auburn *Aug 29*, 19*22*

20-UNDERTAKER

Edwin Easton *916*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 67176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 67176

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2774 Tivoly Ave. ST. 9 WARD)

2. FULL NAME

(a) RESIDENCE NO. 2774 Tivoly Ave. ST. 9 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced

HUSBAND OF

WIFE OF

C Geo. Hickey

6 DATE OF BIRTH (month, day, and year) Sept 28 1880

7 AGE

Years Months Days

41 11 3

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Ebert Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Juliana Hoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

C Geo. Hickey 2774 Tivoly Ave

15 AUG 30 1922

ROBERT M. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1922

17 I HEREBY CERTIFY, That I attended deceased from

May 26 1922 to August 29 1922.

that I last saw her alive on August 28 1922.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Exhaustion

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. B. Buxton M. D.

829 1922 (Address) 301 E. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL Holy Redeemer Ch. 9-1 1922

20 UNDERTAKER

E. B. Harter 115 E. West St.

D 67177

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No *University Hospital* ST.: *4* WARD)

2-FULL NAME

Clara Thomas

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

(Usual place of abode)

Laurel, Maryland ST.: WARD.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

5

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced *HUSBAND* of *James Thomas* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *1896*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
26 *X* *X*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

X

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Frank Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Fertie Ridout

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Herbert Records

15

AUG 30 1922

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *8-29-22*

17

I HEREBY CERTIFY, That I attended deceased from

8/24, 19*22*, to *8/29*, 19*22*that I last saw her alive on *8/29*, 19*22*and that death occurred, on the date stated above, at *7:30 p.m.*

The CAUSE OF DEATH* was as follows:

Surgical Shock
(Post-operation)(duration) yrs. mos. ds. *1/2*

CONTRIBUTORY (Secondary)

Behavior Tubo-Ovarian Abscess(duration) yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death?

*Unknown*Did an operation precede death? *yes* Date of *8/29/22*

Was there an autopsy?

yes

What test confirmed diagnosis?

clinical finding(Signed) *R. B. Jones*

M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in death, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Laurel Md.**8-30-22*

20 UNDERTAKER

ADDRESS

Er B Harle 116 E West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

67178

CERTIFICATE OF DEATH.

90[✓] D 67178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2523 Guilford Ave. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Steenken

(a) RESIDENCE. NO. 2523 Guilford Ave. ST. 12 WARD. Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 57 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Widow

6a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Daniel Steenken

6 DATE OF BIRTH (month, day, and year) December 6-1846

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

75 8 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Hanover Germany

10 NAME OF FATHER

Mr. Emil

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hanover Germany

12 MAIDEN NAME OF MOTHER

Sophia Cordas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hanover Germany

PARENTS

14 Informant (Address) Mrs. Gertrude C. Steenken (Sister) 2523 Guilford Ave.

15

AUG 30 1922

ROBERT H. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-28 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3, 1922, to Aug. 28, 1922,

that I last saw her alive on Aug. 28, 1922,

and that death occurred, on the date stated above, at 10:15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. A. Steenken, M. D.

, 19 (Address) 3949 Greenmount Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Aug 30 1922

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

158044 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67179

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST. 6 WARD)

2-FULL NAME

(a) RESIDENCE NO. 3003 Fair Ave. City ST. 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

Ella Gruber (wife)6 DATE OF BIRTH (month, day, and year) May 27 18887 AGE Years 33 Months 3 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER George Gruber Maryland11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.12 MAIDEN NAME OF MOTHER Kate Alexander13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.14 Informant Johns Hopkins Hosp. Records (Address)

AUG 30 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1922, to Aug 29, 1922, that I last saw him alive on Aug 27, 1922, and that death occurred, on the date stated above, at 8.45 A m.

The CAUSE OF DEATH* was as follows:

Meningitis specific etiology not determined(duration) 1 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) None yrs. None mos. None ds.18 Where was disease contracted if not at place of death? At homeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Lumbar puncture (Signed) Francis R. Diena, M. D.19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Parlowood Cemetery DATE OF BURIAL Sept 1 192220 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. W. 1st

tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67180

CERTIFICATE OF DEATH.

65-001

D 67180

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 Aliceanna ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Zajic(a) RESIDENCE NO. 1933 Aliceanna ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28-19027 AGE Years 20 Months 6 Days 27 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher Training(b) General nature of industry, business, or establishment in which employed (or employer) School Student

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)10 NAME OF FATHER Frank Zajic11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)12 MAIDEN NAME OF MOTHER Julia Burkesh13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)14 Informant Julia Zajic (Address) 1933 Aliceanna St.15 AUG 30 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27-192217 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to Aug 27, 1922.that I last saw him alive on Aug 27, 1922.and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Symphatic Leukemia
acute(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Blood. Picture(Signed) Samuel S. Fisher, M. D., 19 (Address) 3325 Park Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery Aug 31 1922

20 UNDERTAKER

ADDRESS

Lilly & Zeiler 4033 Maple

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE (No. 11 Penn

2-FULL NAME

(Residence in Baltimore: No. 11 Penn St

REGISTERED NO. C

ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str. 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

AUG 30 1922

ROBERT A. KRAUTER,

REGISTRAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

67182

CERTIFICATE OF DEATH.

185

D 67182

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hop 3* St. *3* Ward)

2-FULL NAME

(Residence in Baltimore: No. *1138 E. Lombard* St.; yrs. *1* mos. *1* ds.)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

*Black*Single,
Married,
Widowed,
or Divorced.
(Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

42 yrs. *1* mos. *1* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).*Virginia*10-NAME OF
FATHER,*unknown*11-BIRTHPLACE
OF FATHER,
(State or Country),*unknown*12-MAIDEN NAME
OF MOTHER,*unknown*13-BIRTHPLACE
OF MOTHER,
(State or Country),*unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. R. A. Elliott*(Address) *1725 Ashland Ave*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 27

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest*
(Inquest, au-topsy or inquiry.) find that said deceased came to *death*
on the day stated above.

The CAUSE OF DEATH* was as follows:

*accident, fell from scaffold**on Aug 14, 22.**Post Mortem at Hopkins**Telomus diagnosed*
(Duration) *7* yrs. *7* mos. *1* ds.CONTRIBUTORY
(Secondary)

(Duration)

yrs.

mos.

ds.

(Signed) *J. S. H. Allen*

M. D.

(Coroner)

8-29-22 (Address) *508 E. Lombard*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death *1* yrs. *1* mos. *1* ds. State *1* yrs. *1* mos. *1* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

*mt auburn**Aug 30, 1922*

20-UNDERTAKER,

ADDRESS

*Mrs. R. A. Elliott**1425 Ashland Ave*

15-

AUG 30 1922

ROBERT H. KRAIG, Registrar

Burial Permit Clerk.

state CAUSE OF DEATH in plain terms, so that it may be properly classified is very important. See instructions on back of certificate.

Waneta Taylor
HEALTH DEPARTMENT - CITY OF BALTIMORE

D 67183

CERTIFICATE OF DEATH.

D 67183

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins* St., *9* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1814 N. Spring* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *Black* 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, 1, (Month) (Day) (Year)

7-AGE, yrs. *18* mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work,
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), *Betta Md*

10-NAME OF FATHER, *Clarence Taylor*

11-BIRTHPLACE OF FATHER, (State or Country), *Indiana*

12-MAIDEN NAME OF MOTHER, *Mary Dean*

13-BIRTHPLACE OF MOTHER, (State or Country), *Betta Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. R. C. Elliott*

(Address) *1725 Ashland Ave*

15- AUG 30 1922 192... ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 26*, 192*2*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) *Starving*

(Signed) *J. S. P. Jones* M. D.

(Coroner.)

Aug 27 1922 (Address) *1725 Ashland Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laurel *Aug 30*, 192*2*

20-UNDERTAKER, ADDRESS

Mrs. R. C. Elliott *1725 Ashland Ave*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

15794484 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 67184
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5) JOHNS HOPKINS HOSPITAL, ST. 5 WARD

2-FULL NAME John Harris.

(a) RESIDENCE NO. 1123 McElderry St. City ST. 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced

HUSBAND of

or WIFE of

Georgie Harris (Mother)

6 DATE OF BIRTH (month, day, and year) Dec 12, 1921.

7 AGE Years 8 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Maryland. (State or country)

10 NAME OF FATHER Ashton Harris.

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Georgia Higgs.

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14

Informant JOHNS HOPKINS HOSPITAL.

AUG 30 1922

ROBERT R. KRAUTER,

Filed

, 19

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 21, 1922, to Aug 22, 1922, that I last saw him alive on Aug 22, 1922,

and that death occurred, on the date stated above, at 7:15 P., m.

The CAUSE OF DEATH* was as follows:

Dysentery not dysentery.

(duration) yrs. mos. 33 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) T. B. Gay, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health.

ADDRESS AUG 20 1922

Information should be carefully supplied. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67185 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 S. Charles St. ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Orbe E. Sparks

(a) RESIDENCE NO.

825 S. Charles St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph A. Sparks

6 DATE OF BIRTH (month, day, and year)

Oct. 31 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

9

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

W. Va.

10 NAME OF FATHER

William Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Sarah Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Mrs. Mabel Gilchrist 825 S. Charles St.

15

Filed

AUG 30 1922

J. H. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 12 1921 to Aug 29 1922

that I last saw her alive on Aug 18 1922

and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

Primary (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. B. Roll, M. D.

8/29/22 (Address) 1203, Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-BURIAL

MAYAL Mrs. Oliver Quetney Aug 31 1922

20 UNDERTAKER

Joseph B. Cook 1003 N. Baltimore

D 67186

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 W. Cross St.

ST. 21 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lillie M. Stallings

(a) RESIDENCE NO.

1217 W. Cross St.

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles T. Stallings

6 DATE OF BIRTH (month, day, and year) Aug. 7 1870

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George W. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Rolie Stanger

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14 Informant Charles T. Stallings (Address) 1217 W. Cross St.

15 Filed AUG 30 1922 J. E. Wilson Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 11 1922 to Aug 29th 1922, that I last saw her alive on Aug 28th 1922, and that death occurred, on the date stated above, at 4:05 A. M.

The CAUSE OF DEATH* was as follows:

Acute Ascending paralysis and uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? at home of patient

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? symptoms + urinalysis (Signed) R. B. Wilson, M. D.

8/29/22 (Address) 1124 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

London Park Bur Aug 31 1922

20 UNDERTAKER Joseph B. Cook 1003 N. Falls St.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Apoplectic

67187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

XX yrs. XX mos. 2 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1922, to Aug 30, 1922, that I last saw him alive on Aug 30, 1922, and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Diffuse Broncho Pneumonia

CONTRIBUTORY (Secondary) Redro. Pharyngeal Abscess (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

15 Filed

AUG 30 1922

ROBERT N. KRAMER,

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67188

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N Arlington Ave ST. 18 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David J Doyle

(Residence in Baltimore: No. 507 N Arlington Ave St. 1 yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, July 16, 1921 (Month) (Day) (Year)

7-AGE, 1 yrs. 1 mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto md

10-NAME OF FATHER, Harry J. Doyle

11-BIRTHPLACE OF FATHER (State or Country), Balto md

12-MAIDEN NAME OF MOTHER, Sachi W. Powell

13-BIRTHPLACE OF MOTHER (State or Country), Nelson Co. Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry J. Powell

(Address) 507 N. Arlington Ave

15- AUG 30 1922 ROBERT R. KRAUTER,

Filed....., 191..... Burial Permit Clerk.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 29th, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 24th 1922, to Aug 29th 1922, that I saw h.c. alive on Aug 29th 1922, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Diphtheria (1)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY..... (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Herman P. Wain M. D.

Aug 25th, 1922 (Address) 833 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cathedral 8-30....., 1922

20-UNDERTAKER ADDRESS 17 N.

H. B. Remington, Son Schneider

CAUSE OF DEATH in plain terms, so that it may be properly understood. important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE 67189

D 67189

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Main St. Mt Wm ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Phillips

(a) RESIDENCE. No. 1406 Main St. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 18 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of— Mrs H. Phillips

6 DATE OF BIRTH (month, day, and year) June 10-1904

7 AGE Years 18 Months 2 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER John W. Lewis

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Katherine Silverman

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Thomas H. Phillips (Address) 1406 Main St

15 AUG 30 1922 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1922, to Aug 29, 1922, that I last saw her alive on Aug 28, 1922, and that death occurred, on the date stated above, at 3 p. m. The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Woodruff M. D.

19 (Address) 252 N. Payne St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Sept. 1, 1922

20 UNDERTAKER ADDRESS

George J. Smith 1000 N. Fayette St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67190

D 67190

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 Hanover ST. 22 WARD) 113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry W. Woods(a) RESIDENCE. NO. 817 Hanover ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

616

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country) Balto10 NAME OF FATHER Harry W. Woods

11 BIRTHPLACE OF FATHER (city or town)

(State or country) md.12 MAIDEN NAME OF MOTHER Fannie Breeden

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14

Informant (Address) Harry W. Woods
817 Hanover St

15

AUG 30 1922ROBERT A. KRAUTER,

Racial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 10, 1922, to Aug 30, 1922,that I last saw him alive on Aug 29, 1922,and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) H. F. Campbell, M. D.(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill

DATE OF BURIAL

Aug 31 1922

20 UNDERTAKER

F. A. Krause & Son

ADDRESS

733 Hanover

D 67191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2203 Boston St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 415 So. Elwood Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-Single,
Married,
Widowed,
or Divorced,
(Write the word.)Married

6-DATE OF BIRTH,

Feb 101863

(Month)

(Day)

(Year)

7-AGE,

596 yrs. 18 mos. 18 ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Letter CarrierBalto. P.O.

9-BIRTHPLACE,

(State or Country).

Balto. Md

10-NAME OF FATHER,

Henry Mentz

11-BIRTHPLACE OF FATHER,

(State or Country).

Pa

12-MAIDEN NAME OF MOTHER,

Mary Zickler

13-BIRTHPLACE OF MOTHER,

(State or Country).

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Irvin Mentz

(Address)

415 So. Elwood Ave

15-AUG 30 1922

ROBERT R. KRAUTER,

Filed

192

Burial Permit Clerk,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 281922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY That I took charge of the

remains described above, held an inquest

(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said inquest

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexyat once

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Aug 28 1922 (Address) Curtis Bay,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

SchwartzSept 1 1922

20-UNDERTAKER,

ADDRESS

Zickler & Zickler1739 Eager

state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67192

D 67192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *119 N. Front* ST., *5* WARD)

2-FULL NAME

(a) RESIDENCE NO. *119 N. Front* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *18* yrs. — mos. ds. How long in U. S., if of foreign birth? *18* yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June - 1886*7 AGE Years *86* Months *2* Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

AUG 30 1922 ROBERT R. KRAUTER, File

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 31st* 19 *22*17 I HEREBY CERTIFY That I attended deceased from *August 20th*, 19 *22*, to *August 31st*, 19 *22*, that I last saw him alive on *August 29th*, 19 *22*, and that death occurred, on the date stated above, at *3 a. m.*

The CAUSE OF DEATH* was as follows:

Acute Debility complicated with Bronchial Asthma.(duration) *2* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) *6* yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? *no*What test confirmed diagnosis *History + observation*(Signed) *Woodward*, M. D., 19 (Address) *6 N. Front St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Holy Redeemer
Fiskel & Fiskel

DATE OF BURIAL

ADDRESS

Sept. 1, 1922
739 Eager

Information should be carefully supplied so that it may be properly classified. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Rudd(a) RESIDENCE NO. 703 Cumberland Place ST. 15 WARD 15
(Usual place of abode) (If non-resident give city or town and State)Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofNot given6 DATE OF BIRTH (month, day, and year) 18937 AGE Years Months Days If LESS than 1 day, hrs. or min.
29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)10 NAME OF FATHER Oscar Rudd11 BIRTHPLACE OF FATHER (city or town) East India
(State or country)12 MAIDEN NAME OF MOTHER Mary J. Bayne13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)14 Informant Hospital Records
(Address) M. T. H.15 AUG 30 1922 ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 192217 I HEREBY CERTIFY, That I attended deceased from
May 13, 1922 to Aug. 27, 1922that I last saw him alive on Aug. 27, 1922and that death occurred, on the date stated above, at 4.05 p. m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis(duration) 1 yrs. 8 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum, X-ray(Signed) Francis Badalucci M. D.8-27-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR DIS- DATE OF BURIAL
MOVAL St. Andrew's Aug 30 192220 UNDERTAKER Edward Ringgold ADDRESS 1463 N. Carey

Information should be carefully reported. Exact statement of OCCASION CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67194

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 Durham ST., 6 WARD)

2-FULL NAME

George E. Horst

(a) RESIDENCE NO.

127 Durham ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 12 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

2

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

Casper Horst

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Henriette Holand

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

14

Informant (Address)

Casper Horst
127 Durham St.

15

File

AUG 30 1922

ROBERT M. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 192217 I HEREBY CERTIFY, That I attended deceased from Aug 29 1922 to Aug 29 1922that I last saw him alive on Aug 29 1922and that death occurred, on the date stated above, at 5:00 p.m.

The CAUSE OF DEATH* was as follows:

Acute EnterocolitisCONTRIBUTORY (Secondary) Acidosis (duration) yrs. mos. 14 ds.18 Where was disease contracted if not at place of death? Country (Balt Co)Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

8/30/22 (Signed) Wm E. Batts, M. D.Address 1002 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.

Baltimore

20 UNDERTAKER

Wendell Dyffel

DATE OF BURIAL

Aug 31 1922

ADDRESS

378 1/2

Information should be carefully supplied so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67195

D 67195

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME George W. Boston(a) RESIDENCE NO. Unknown ST. WARD (Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18657 AGE Years Months Days If LESS than 1 day, hrs. or min. 57 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records (Address) Municipal Hospital15 AUG 30 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28 192217 I HEREBY CERTIFY, That I attended deceased from August 17, 1922, to August 28, 1922, that I last saw him alive on August 28, 1922, and that death occurred, on the date stated above, at 12:15 P.M. The CAUSE OF DEATH* was as follows:Myocardial InsufficiencyCONTRIBUTORY (Secondary) Cirrhosis of liver (duration) yrs. mos. ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. McNeill M. D.Address Municipal Hospital
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Carr Hill Cem.

20 UNDERTAKER

Jas. J. Faherty & Son

DATE OF BURIAL

9/1/22

ADDRESS

1318 LightExact statement of OCCUR-
rence should be carefully supplied. For instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67196

D 67196

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 St Paul St

ST.: 11

WARD)

2-FULL NAME

Eliza Gibson Hazlett

(a) RESIDENCE. No. 814 St Paul St

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 25 ds.

ST.: 11

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug 23rd 1854

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

67

11

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

James Hazlett

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Warren, Ohio

12 MAIDEN NAME OF MOTHER

Annie Sears

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Tollett Co Md

14

Informant
(Address)J. P. Russell
209 Woodlawn Rd. Baltimore

15

Filed

Robert P.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29th 192217 I HEREBY CERTIFY, That I attended deceased from
Noretha, 1922, to Aug. 29th, 1922.that I last saw her alive on Aug. 29th, 1922.

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

CONTRIBUTORY (Secondary) acute Pancreatitis
(duration) yrs. 9 mos. 3 ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

M. M. Dabney

M. D.

(Address) Ruxton Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem

8-31 1922

20 UNDERTAKER

Hy. J. Jenkins

Address

M. J. J. J.

Baltimore

6301922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67197

67197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home and Infirmary*
CITY OF BALTIMORE: (No. *126 W. Broadway* ST., *27* WARD)REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)2-FULL NAME *Mr. Walter P. Summers*(a) RESIDENCE NO. *330 Roland Ave.* ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. _____ mos. _____ ds. _____ How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of *Grace Hubbard Summers*
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *48* Months *1* Days *12* If LESS than 1 day, hrs. _____ min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Pres. of the

(b) General nature of industry, business, or establishment in which employed (or employer)

Summers

(c) Name of employer

Fertilizer Co.

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Chas. S. Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Mary R. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant (Address)

Mrs. Grace A. Summers
330 Roland Ave R.P.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 30 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 28*, 1922, to *Aug 30*, 1922, that I last saw him alive on *Aug 30*, 1922, and that death occurred, on the date stated above, at *6 00 a.m.*

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
General Peritonitis(duration) yrs. _____ mos. *2* ds.

CONTRIBUTORY (Secondary)

Appendicitis, acute(duration) yrs. _____ mos. *7* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes Date of *Aug 25 1922*

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

Richard G. Cobble, M. D.

19

(Address) *Church Home and Infirmary*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Donald Ridge
*H. W. Jenkins**9-1 1922*
Millersville
Ortland

30 1922

Robert P. Harrison,

Registrar

Burial Permit Clerk

Information should be carefully supplied. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

ST. 27 WARD

ST. WARD

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1922.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1922, to Aug. 29, 1922, that I last saw him alive on Aug. 29, 1922, and that death occurred, on the date stated above, at 8:55 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration)

yrs. mos. 3 ds.

CONTRIBUTORY Chronic Myocarditis

(Secondary)

(duration)

yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Atlantic City N. J.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? yes.

(Signed)

James C. Clark, M. D.
Aug. 29 1922 (Address) Zetorbe Opt. Char. side at St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

ADDRESS

20 UNDERTAKER

George Schilling + Sons 1126 Monument St.

30 1922

Exact statement of

Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67199

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1127 Carrollton Ave. ST. 18 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1127 Carrollton Ave. ST. 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Color Red Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~

6 DATE OF BIRTH (month, day, and year) Oct - 1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Laborer 40

General

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/ 19 22

17 I HEREBY CERTIFY, That I attended deceased from 8/14/ 19 22 to 8/28/ 19 22 that I last saw him alive on 8/27/ 19 22

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

30/ 19 22 (Address) 1197 Carrollton Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

G 30 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp ST.* WARD) *7*2-FULL NAME *Elvise Thompson*(a) RESIDENCE NO. *Chase, Maryland ST.* WARD *Chase Md*

(Usual place of abode)

Length of residence in city or town where death occurred *Unknown* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Single*

5a If married, widowed, or divorced

HUSBAND OF
(or) WIFE OF*Theodore & Vivian Thompson*6 DATE OF BIRTH (month, day, and year) *1921*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Chase Maryland

10 NAME OF FATHER

Theodore Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Portland Rose Island

12 MAIDEN NAME OF MOTHER

Gosh

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Texas

14

Informant (Address)

*Johns Hopkins Hosp Records**Robert P. Harrison*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 29 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Aug 24 1922 to Aug 29 1922*that I last saw her alive on *Aug 29 1922*and that death occurred, on the date stated above, at *10:00 P. m.*

The CAUSE OF DEATH* was as follows:

Purpura haemorrhagica

(duration) 0 yrs. 0 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Horton Casparis* M. D.19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Chase Md

20 UNDERTAKER

William H. Shriver, 1018 Belmont

DATE OF BURIAL

Aug 31 1922

ADDRESS

mation should be carefully supplied. Exact statement of OCCUR-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

6301922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67201

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *723 Mc Henry*) ST., *21* WARD2-FULL NAME *Edgar J. Fromm*(a) RESIDENCE NO. *723 Mc Henry* ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. _____ mos. _____ ds. _____(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

Single, Married, Widowed, Divorced, (write the word)

*Male**White**Married*5a If married, widowed, or divorced, HUSBAND of (or) WIFE of *Christina Fromm*6 DATE OF BIRTH (month, day, and year) *Apr 1 1894*

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or min.

*28**4**26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Iron Worker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Wm J. Fromm*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Esther L. Fromm*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14

Informant (Address) *723 Mc Henry*

15

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 28 1922*17 I HEREBY CERTIFY, That I attended deceased from *Mar 1*, 19 *22*, to *Aug 28*, 19 *22*, that I last saw him alive on *Aug 28*, 19 *22*, and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Interstitial(duration) yrs. *3* mos. _____ ds. _____

CONTRIBUTORY (Secondary)

(duration) yrs. _____ mos. _____ ds. _____

18 Where was disease contracted If not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harry Boyd*, M. D.19 *22* (Address) *723 Mc Henry*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *Southern Park An*DATE OF BURIAL *8/31/22*20 UNDERTAKER *George A. Shirley*ADDRESS *723 Mc Henry*

30 1922

Burial Permit Clerk.

Exact statement of cause of death should be carefully supplied. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 67202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 12 Hazel St. Curtis Bay, St. 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John Newman.

1 0 15

(Residence in Baltimore: No. 12 Hazel St. Curtis Bay, St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male.	4-COLOR OR RACE, White.	5-Single, Married, Widowed, or Divorced, (Write the word.) Single
6-DATE OF BIRTH, August 15th. 1921. 1 (Month) (Day) (Year)		
7-AGE, 1 yrs. 0 mos. 15 ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. None. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country). Baltimore, Md.		

PARENTS.	10-NAME OF FATHER, John Newman.
	11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md.
	12-MAIDEN NAME OF MOTHER, Bertha Brockley.
	13-BIRTHPLACE OF MOTHER, (State or Country). Pennsylvania.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Newman. (mother)

(Address) 12 Hazel St. Curtis Bay.

15-

Robert P. Harrison,

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 30th. 1922. 192.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dysentery and enteritis.
Scleremia.

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Otto Reinhardt M. D.
(Signature) (Duration) yrs. mos. ds.
(Address) 1018 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS

30 1922

192

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67203

CERTIFICATE OF DEATH.

154/0 67203

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Brindall ST. 24 WARD)REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 412 Brindall ST. 24 WARD.(Usual place of abode)
(If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE R 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____6 DATE OF BIRTH (month, day, and year) 5/30/227 AGE Years Months Days If LESS than 1 day, hrs. or 2 min.
— — — — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

PARENTS

14 Informant (Address) Robert P. Harrison, 412 Brindall St.

15 Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 19 2217 I HEREBY CERTIFY, That I attended deceased from Aug 30, 19 22, to Aug 30, 19 22, that I last saw him alive on Aug 30, 19 22, and that death occurred, on the date stated above, at 11:30 m.
The CAUSE OF DEATH* was as follows:
Thrombosis Cerebri

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Michael M. D.19, 19 22 (Address) 1219 Indiana St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

UG 01922

Burial Permits Clerk

67204 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 67204

67204

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 Webster ST. 24 WARD)

2-FULL NAME

Mary E. Brummitt

(a) RESIDENCE NO. 1734 Webster ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

V. W. Brummitt

6 DATE OF BIRTH (month, day, and year) Oct 3/1851

7 AGE Years Months Days If LESS than 1 day, hrs or min.

70 8 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at 037

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Frederick Co Md

10 NAME OF FATHER

Joseph Stumel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Frederick Co Md

12 MAIDEN NAME OF MOTHER

Mary E. Stumel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Frederick Co Md

14

Informant (Address)

V. W. Brummitt 1734 Webster St

15

ROBERT N. KRAUTER, Registrar

AUG 31 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1922

17 I HEREBY CERTIFY, That I attended deceased from 1.29.20, 19 to 8.28.22

that I last saw her alive on 8.26.22

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Myopathy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical only

(Signed) P. Lewis S. Fowler, M. D.

178.22 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

NOVA 100 Christ Frederick M Aug 31 1922

20 UNDERTAKER

ADDRESS

William back 5025 N. 1st St

Information should be carefully supplied. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

2-FULL NAME

Lizzie Davis

(a) RESIDENCE NO.

713 W. Lanvale St

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female BlackMarried5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown

6 DATE OF BIRTH (month, day, and year)

1864

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.58

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Virginia10 NAME OF FATHER Henry Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia12 MAIDEN NAME OF MOTHER Mildred Rumson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia14 Informant Hospital Records,(Address) Municipal Hospital.15 AUG 31 1922ROBERT H. KRAUTER

Registrar

Burial Place Green

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28 1922

17

I HEREBY CERTIFY, That I attended deceased from
August 22, 1922, to August 28, 1922.that I last saw her alive on August 27, 1922.and that death occurred, on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:

SyphiliticCONTRIBUTORY
(Secondary)Syphilitic(duration) 30-40 yrs. mos. ds.(duration) ? yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Neil

M. D.

8/28/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Asbury Green Cemetery

ADDRESS

20 UNDERTAKER

Mrs. Charles G. Bailey 1721 Jefferson St.

Exact statement of OCCUPATION should be carefully supplied. For information on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

67206

HEALTH DEPARTMENT—CITY OF BALTIMORE

67206

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 S. Chester ST., 1 st. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JADWIGA M. KOSLOWSKA,

(a) RESIDENCE No. 521 S. Chester

ST., 1 st. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female, White, Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 16-1921.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

1 0 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, MD.,

10 NAME OF FATHER Frank Koslowski,

11 BIRTHPLACE OF FATHER (city or town) Poland,

12 MAIDEN NAME OF MOTHER Mary Kraus,

13 BIRTHPLACE OF MOTHER (city or town) Poland.

14 Informant Mary Koslowska, (Mother)
(Address) # 521 S. Chester Street15 AUG 31 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1922.

17 I HEREBY CERTIFY, That I attended deceased from 27, 1922, to 28, 1922, that I last saw him alive on 28, 1922,

and that death occurred, on the date stated above, at 7.50 A-m.

The CAUSE OF DEATH* was as follows:

Acute Infectious Intoxication

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Kauter, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Stamishaw, Conn.,

DATE OF BURIAL

Aug 31, 1922.

20 UNDERTAKER

M. J. Sadowski.

ADDRESS

405 S. Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67207

113 D 67207

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 W. Mulberry ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 715 W. Mulberry St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mr. 4-COLOR OR RACE. Col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Write the word.

6-DATE OF BIRTH. July 7, 1922 (Month) (Day) (Year)

7-AGE. 1 yr. 22 mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, James Blair

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER, Mrs. Brooks

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Daniel Zestus

(Address), 916 E. ...

AUG 31 1922

ROBERT R. KRAUTER,

Filed 191 ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 29, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1922, to ... 1922,

that I saw him alive on Aug. 22, 1922,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

acute gastric enterocolitis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

Aug. 30, 1922 (Address) 724 N. Greene St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt. Beulah Co. Aug. 31, 1922

20-UNDERTAKER, ADDRESS 916 E. ...

N.B.—Every item of information on this certificate is important. See instructions on back of certificate.

D 67208

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N Mount ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Enoch Loudan(a) RESIDENCE NO. 314 N Mount ST., 19 WARD(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov 5 - 19127 AGE Years 9 Months 2 Days 5
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work off

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md10 NAME OF FATHER Orlie Loudan11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va.12 MAIDEN NAME OF MOTHER Lillis Polier13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.14 Informant Orlie Loudan
(Address) 314 N Mount St15 AUG 31 1922 ROBERT R. KRAUTER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 192217 I HEREBY CERTIFY, That I attended deceased from
Aug 25, 1922, to Aug 30, 1922,
that I last saw him alive on Aug 30, 1922,
and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Marasmus or wasting dis-
due to improper care and
attention(duration) yrs. 3 mos. ds.CONTRIBUTORY Malnutrition
(Secondary) (duration) yrs. 3 mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical(Signed) Bernard S. Smith, M. D.831, 1922 (Address) 707 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL St. AuburnDATE OF BURIAL
8/31/22
ADDRESS
1400 N. York St20 UNDERTAKER
Sam. W. Chase - sonExact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67209

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1341 Calhoun St. 15 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1341 Calhoun St. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Harry Davis

6 DATE OF BIRTH (month, day, and year)

Jul 10 1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

5

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Co.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Martha Louise

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Marion Davis 341 Calhoun St.

15

File

AUG 31 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 25th, 1922, to Aug 30th, 1922.

that I last saw him alive on Aug 29, 1922.

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Infected Abscess tooth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) A. C. Brown, M. D.

Address 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Union Chapel Aug 31 1922

20 UNDERTAKER

Saul H. Hays

ADDRESS

57

HEALTH DEPARTMENT—CITY OF BALTIMORE

67210

CERTIFICATE OF DEATH.

67210

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hospital* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

(Residence in Baltimore: No. *114 S. Caroline* St.; yrs.,..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *Black* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*6-DATE OF BIRTH. *May 5* 189*4*
(Month) (Day) (Year)7-AGE, *28* yrs. *3* mos. *21* ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Presser*
(b) General nature of industry, business, or establishment in which employed (or employer) *Tailor*9-BIRTHPLACE, (State or Country), *Virginia*10-NAME OF FATHER, *David Jones*11-BIRTHPLACE OF FATHER, (State or Country), *Virginia*12-MAIDEN NAME OF MOTHER, *Mary Blunt*13-BIRTHPLACE OF MOTHER, (State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Martha Patterson (Sister)*(Address) *New York City*

AUG 31 1922 ROBERT R. KRAUTER,

Filed 1922

Burlal Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Aug 25* 192*2*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage due to knife wounds inflicted by Willie (female) Johnson (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *J. H. Potter* M. D.8-30 1922 (Address) *508 E North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

*Robert Cemetery Aug 31, 1922*20-UNDERTAKER, ADDRESS *Edmund Brown 1631 Orleans*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor* ST. *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Joseph Kellenberg*(a) RESIDENCE. NO. *Preston Valley* ST. *40* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Unknown*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1853*7 AGE Years *68* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *ooo*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant *Sister Terrence* (Address) *Preston Valley St.*

15

AUG 31 1922 ROBERT H. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 29* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *to record* 19*22* to 19*22*that I last saw him alive on *Aug 27* 19*22*and that death occurred, on the date stated above, at *8 C* m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. A. Warner* M. D. 19*22* (Address) *1133 Valley St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Cathedral**Aug 31* 19*22*

20 UNDERTAKER

ADDRESS

H. C. Friedfeld 914 Greenbush Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST. _____ WARD _____)

2. FULL NAME

(a) RESIDENCE NO. _____ ST. _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds.

How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____

4 COLOR OR RACE _____

5 Single, Married, Widowed, or Divorced, (write the word) _____

5a If married, widowed, or divorced _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) _____

7 AGE _____

Years _____

Months _____

Days _____

If LESS than
1 day, _____ hrs.
or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____
(State or country) _____

10 NAME OF FATHER _____

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) _____

12 MAIDEN NAME OF MOTHER _____

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) _____

14

Informant
(Address) _____

AUG 3 1 1922

ROBERT R. KRAUTER,
Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) _____

17 I HEREBY CERTIFY, That I attended deceased from _____
July 27, 1922, to Aug 30th, 1922,
that I last saw him alive on Aug 30th, 1922,
and that death occurred, on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY
(Secondary) _____

(duration) _____

yrs. _____

mos. _____

ds. _____

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____

19

(Address) _____

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL _____

DATE OF BURIAL _____

20 UNDERTAKER _____

ADDRESS _____

D 67213

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67213

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Wmams Ave.*)ST., *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST., _____ WARD _____

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *8-30-1922*

7 AGE

Years

Months

Days

If LESS than 1 day, 7 hrs. or 2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

AUG 31 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from *Aug 30*, 19*22*, to *Aug 30*, 19*22*.that I last saw him alive on *Aug 30*, 19*22*.and that death occurred, on the date stated above, at *6* p.m.

The CAUSE OF DEATH was as follows:

Prematurity (7 1/2 Mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of _____Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *G. F. Goff*

M. D.

19 (Address) *Woodsward's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 67215

HEALTH DEPARTMENT—CITY OF BALTIMORE

1290 67215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1100 Pennington* ST. *1100 Pennington* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *1100 Pennington* ST. *1100 Pennington* WARD.
(Usual place of abode)Length of residence in city or town where death occurred *46* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *Swedish White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *James Hozela*6 DATE OF BIRTH (month, day, and year) *June 19 1880*7 AGE Years Months Days *42 2 10* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Bohmer's*9 BIRTHPLACE (city or town) (State or country) *Bohmer's*10 NAME OF FATHER *Not known*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Berlin*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Not known*14 Informant (Address) *James Hozela*
*1100 Pennington*15 File *AUG 31 1922* ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 30 1922*17 I HEREBY CERTIFY, That I attended deceased from *Oct. 22 1921* to *Aug 30 1922*that I last saw him alive on *Aug 30 1922*and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(duration) *1* yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

(duration) *1* yrs. *6* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *William H. Sakel* M. D.(Address) *1431 801st St. Buwoodh*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Oak Hill*20 UNDERTAKER *Frank R. Smith*DATE OF BURIAL *Sept 1922*ADDRESS *1866 Wood*

Information should be carefully supplied. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--1-10-21-M&T-1500 Bks.

157839 HEALTH DEPARTMENT--CITY OF BALTIMORE

D 67216

CERTIFICATE OF DEATH.

X 32 D 67216

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp* ST., *7* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White

Married

6 If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Callie Chilton (wife)

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

33

?

?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Johns Hopkins Hospital

15

AUG 31 1922

ROBERT A. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 30 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Aug 16, 1922, to *Aug 30*, 1922,

that I last saw him alive on *Aug 30*, 1922,

and that death occurred, on the date stated above, at *847 P.* m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos. ds. *5*

CONTRIBUTORY *T. B. Service tract*

(Secondary)

(duration) yrs. mos. ds. *2*

18 Where was disease contracted

if not at place of death?

N. C.

Did an operation precede death? *Yes* Date of *22 Aug*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Autopsy*

(Signed) *Franklin P. Johnson*, M. D.

, 19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

Pilato maitua N. C.

Joseph Adams

DATE OF BURIAL

Aug 30 1922

ADDRESS

221 N. B. St.

D 67217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 West Lombard ST., 18 WARD)2-FULL NAME Caroline Elizabeth Baker(a) RESIDENCE No. 1123 West Lombard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. V mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Baker6 DATE OF BIRTH (month, day, and year) July 9th 18597 AGE Years 63 Months 1 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer alone9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER Herman L. Udich11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Elise Ewig13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant George Baker (Address) 1123 West Lombard15 AUG 31 1922

ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30th 192217 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Aug 29, 1922that I last saw her alive on Aug 29, 1922and that death occurred, on the date stated above, at 9 8 m.

The CAUSE OF DEATH* was as follows:

chronic interstitial nephritis(duration) yrs. mos. ds. husband

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? urinalysis(Signed) Walter A. Cox, M. D.8/30, 1922 (Address) 547 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

9/1/1922

20 UNDERTAKER

Mr. Nebel & Son 2503 Calverton

ADDRESS

WFC

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67218

D 67218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2123 E. Preston St.* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *2123 E. Preston St.* ST.: *8* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug. 30-22*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *000*(c) Name of employer *Balt.*9 BIRTHPLACE (city or town) (State or country) *Balt.*10 NAME OF FATHER *Godfrey Herder*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balt.*12 MAIDEN NAME OF MOTHER *Margaret Heagerty*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balt.*

14

Informant (Address) *Ed Herder 2123 E. Preston St.*

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 31 1922*17 I HEREBY CERTIFY, That I attended deceased from *Aug 30, 1922*, to *Aug 31, 1922*, that I last saw him live on *Aug 30, 1922*, and that death occurred, on the date stated above, at *830a m.*

The CAUSE OF DEATH* was as follows:

Premature birth Eight months twin

(duration) yrs. mos. / ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *yes*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical*(Signed) *A. C. Henry* M. D.Address *2600 E. Baltimore St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery Aug 31 1922

20 UNDERTAKER

ADDRESS

Frank Lassamson Fullerton

Exact statement of Occurrence. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

G3 11922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. ST. 17* WARD)

2-FULL NAME

Mrs. Bessie J. Burall.

(a) RESIDENCE NO.

417 E. 25th St. City

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Single*

5a If married, widowed, or divorced

*Widowed**Mrs. Emma Burall mother*

6 DATE OF BIRTH (month, day, and year)

Oct. 30 - 1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*37**10**—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blank

(b) General nature of industry, business, or establishment in which employed (or employer)

A. G. & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

William M. Burall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emma Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Johns Hopkins Hosp. Secor

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 30 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Aug 26 1922 to Aug 30 1922.*that I last saw her alive on *Aug 30 1922.*and that death occurred, on the date stated above, at *2:30 a.m.*

The CAUSE OF DEATH* was as follows:

Brain tumor - left cerebral(duration) *20* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*At home*Did an operation precede death? *Yes* Date of *Aug 28*Was there an autopsy? *Partial - head*What test confirmed diagnosis? *Operation*(Signed) *F. P. Reichert* M. D., 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Grundy Ridge**Aug 1 1922*

20 UNDERTAKER

ADDRESS

*Horace H. Burgee**163 N. Hollid*

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

U63 11922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67220

71-002 67220

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 N. Patt. Ph. Ave. 8 ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James, J. Carter

(a) RESIDENCE NO.

1008 N. Patt. Ph. Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 29th, 22

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Balt. Md.

10 NAME OF FATHER

Thomas. Wharter

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Inez. Munchel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Md.

14

Informant
(Address)Thomas W. Carter
1008 N. Patt. Ph. Ave

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1922

17

HEREBY CERTIFY, That I attended deceased from
Aug 2, 1922, to Aug. 30, 1922,
that I last saw him alive on Aug 30, 1922

and that death occurred, on the date stated above, at 1230 a. m.

The CAUSE OF DEATH* was as follows:

Septic-Spinal Meningitis

(duration)

yrs.

mos.

30 ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

5 ds.

18 Where was disease contracted
if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

J. H. Robinson

M. D.

, 19

(Address)

212 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore

DATE OF BURIAL

Sept 1 1923

20 UNDERTAKER

Geo. E. Crook.

ADDRESS

North Harbor

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

31 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

67221

CERTIFICATE OF DEATH.

10

67221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

6208 Bond

ST.

3

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Stella Kamienski

(a) RESIDENCE NO.

6208 Bond

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 24 1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

10

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bay St Louis

10 NAME OF FATHER

William Kamienski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Rose Raczynski

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Rose Kamienski

15

SEP 1-1922

ROBERT H. RAUTER,

Bureau Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 31 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 31, 1922, to Aug. 31, 1922.

that I last saw her alive on Aug. 31, 1922,

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria Laryngitis.

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

John H. Reiburger

M. D.

, 19

(Address)

1709 Alameda St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

1065 Basary St

1 1922

John M. Weber 1803 Bond

ation should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION should be supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1012 Farm

ST.

3

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anthony Varrella

(a) RESIDENCE. NO.

1012 Farm

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

20

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

65

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 1 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Russian 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy

10 NAME OF FATHER

Frank Varrella

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Christina

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Joseph Varrella

1012 Farm

15

SEP 1-1922

ROBERT S. RAUTER

Registrar

Bertal Farm Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 30 1922

17 I HEREBY CERTIFY, That I attended deceased from

June 30 1922 to Aug 31 1922

that I last saw him alive on Aug 31 1922

and that death occurred, on the date stated above, at 20 m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

cr. bronchitis

(duration) yrs. mos. ds.

15 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chs. Jasta M. D.

19 (Address) 210 Pearl St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

Sep 2 1922

20 UNDERTAKER

ADDRESS

Mendell D. J. & Son

310 N

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ D 67223

67223

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Hamores ST. 23 WARD)

2-FULL NAME

Ellsworth Bush(a) RESIDENCE. NO. 1907 Hamores ST. 23 WARD. (If nonresident give city or town and State)Length of residence in city or town where death occurred yrs. 1 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22-19227 AGE Years 1 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.10 NAME OF FATHER James A. Bush11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.12 MAIDEN NAME OF MOTHER May V. Green13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.14 Informant Mr. Bush (Address) 1907 Hamores15 SEP 1-1922 ROBERT A. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 192217 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1922, to Aug 31, 1922, that I last saw him live on Aug 31, 1922, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro EnteritisCONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Cholera
(Signed) R. A. Krauter, M. D.
31, 1922 (Address) 1644 S. E. 1st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

M. Olivet Cem

20 UNDERTAKER

J. F. M. Gully 130 E. Fort

DATE OF BURIAL

9/1 1922

ADDRESS

D 67224

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67224 4

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gus Gotthardt(a) RESIDENCE NO. 1245 Battery Ave ST. 24 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 5 mos. 30 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----6 DATE OF BIRTH (month, day, and year) March 1 - 18737 AGE Years 49 Months 5 Days 30 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER Gus Gotthardt11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Unkn wn13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records, (Address) Municipal Hospital.15 ROBERT R. KRAUTH Registrar

Dental Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 19 2217 I HEREBY CERTIFY, That I attended deceased from August 23, 19 22, to August 30, 19 22.that I last saw him alive on August 30, 19 22, and that death occurred, on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritisunknown (duration) yrs. mos. ds.CONTRIBUTORY Infected Varicose ulcers (Secondary)unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ---Was there an autopsy? noWhat test confirmed diagnosis? --- (Signed) R. F. Russell, M. D.8/31/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Paul's reformed ben9/2 19 22

20 UNDERTAKER

ADDRESS

J. F. Mc Gully130 E. Fort

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67225 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1434 Anthony ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Albert J. Samu

(a) RESIDENCE NO.

1434 Anthony

ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 10 mos.

ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Magdalena Samu

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 11, 1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

10

10

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

861

(b) General nature of industry, business, or establishment in which employed (or employer)

Police Officer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

Henry Samu

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md. Kan

12 MAIDEN NAME OF MOTHER

Mrs. Samu

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md. Kan

14

Informant

(Address)

Mrs. Magdalena Samu
1434 Anthony St.

15

SEP 1-1922

ROBERT H. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 25, 1922 to Aug 31, 1922

that I last saw him alive on Aug 31, 1922

and that death occurred, on the date stated above, at 1:15 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Regeneration
Endocarditis

CONTRIBUTORY (Secondary)

18 Where was disease contracted
If not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 20

What test confirmed diagnosis?

(Signed)

J. L. 22 POON (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Oak Lawn Cemetery

20 UNDERTAKER

Henry Horch Son

DATE OF BURIAL

MOYAL

Sept. 2, 1922

ADDRESS

1391 E. Eager

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67226

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 N Tullon Ave. ST. 70 WARD)

2-FULL NAME

Maria White Musgrove

(a) RESIDENCE NO.

524 N Tullon Ave. ST. 70 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 5 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

4

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Stephen Musgrove

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Catharina White

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Agnes T. Musgrove 524 N Tullon Ave.

15

SEP 1-1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1922

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1922, to August 30, 1922, that I last saw her alive on August 30, 1922, and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

CONTRIBUTORY (Secondary) (duration) yrs. 1 mos. 1 ds. Ac. Dilatation of Heart

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Chemical (Signed) E. W. Coolahan, M. D.

Address 24 N Tullon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cem

DATE OF BURIAL

9/2/22

20 UNDERTAKER

George A. Tully Tully & Son

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67227.

CERTIFICATE OF DEATH.

D 67227.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *3718 Claremont* ST., *76* WARD)

2. FULL NAME

Sabina Bolckhard.

(a) RESIDENCE NO.

(Usual place of abode) *3718 Claremont* ST., *76* WARD
(If non-resident give city or town and State)
Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., if of foreign birth? *30* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced
HUSBAND of *Mar. Bolckhard.*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Aug. 30 - 1846*7 AGE Years *76* Months *0* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*(b) General nature of industry, business, or establishment in which employed (or employer) *at home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Germany*10 NAME OF FATHER *Carl Franz*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Mary Mangel*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *Mar. Bolckhard*
(Address) *3718 Claremont St.*

15 SEP 1 - 1922

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug. 31 1922*17 I HEREBY CERTIFY, That I attended deceased from *Jan 27, 1922* to *Aug 31, 1922*
that I last saw him alive on *Aug 27, 1922*and that death occurred, on the date stated above, at *7.30 A. M.*
The CAUSE OF DEATH* was as follows:*Leukemia*
(duration) yrs. *8* mos. ds.CONTRIBUTORY (Secondary) *Narrowing*
(duration) yrs. *4* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. D. Schuler*, M. D., 19 (Address) *101 N. E. Capital St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cem.

20 UNDERTAKER

Lilly & Ziehl

DATE OF BURIAL

Sept. 2 1922

ADDRESS

403 S. Mott St.

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

15-8008 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67228

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: (NO. J. HOPKINS HOSPITAL, 8 WARD)

2-FULL NAME Harry Smith.

(a) RESIDENCE NO. 11004, Mount St. City.

WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single

6 If married, widowed, or divorced HUSBAND of (or WIFE of) Mary Smith (mother).

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER William Wilmer.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Smith.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant J. HOPKINS HOSPITAL.

(Address)

15

Filed

SEP 1-1922

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 24 1922, to Aug 25 1922.

that I last saw him alive on Aug 25 1922.

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Hereditary Syphilis

(duration) yrs. mos. ds. Life

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds. 1

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis? Wassermann

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

SEP 1-1922

157937 HEALTH DEPARTMENT-CITY OF BALTIMORE
D 67229

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hosp. St. 9* WARD)

2-FULL NAME

(a) RESIDENCE NO. *Bertrand, Va.* ST. *9* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *0* yrs. *0* mos. *9* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White Married*6 If married, widowed, or divorced HUSBAND of (or) WIFE of *Demetrius Connellee*7 DATE OF BIRTH (month, day, and year) *April 1, 1854*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Farmer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 SEP 1 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *August 31, 1922*17 I HEREBY CERTIFY, That I attended deceased from *August 22, 1922*, to *August 31, 1922*, that I last saw him alive on *August 31, 1922*, and that death occurred, on the date stated above, at *11:05 P. M.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) yrs. *5* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *At home.*Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*What test confirmed diagnosis? *Electrocardiogram*(Signed) *E. Coules Andrus*, M. D., 19 (Address) *Johns Hopkins Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
COVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Sonora Va *Sept 1 1922*
Stewart and Mowen Co *108 W. North St.*
William J. Woodhouse

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67230

CERTIFICATE OF DEATH.

D 67230

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Vine ST. 70 WARD)

2. FULL NAME

(a) RESIDENCE NO. 1827 Vine ST. 70 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph Richardson

6 DATE OF BIRTH (month, day, and year)

7 AGE

63

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Harwood Co

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Anna Bremer 1827 Vine St

15

SEP 1 - 1922

ROBERT N. KRAUTER Registrar

Burial Permit Blank.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 19 2217 I HEREBY CERTIFY, That I attended deceased from Aug 22, 19 22, to Aug 29, 19 22that I last saw her alive on Aug 29, 19 22, at 530 P m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Dep. Intestinal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick M. Mendenhall, M. D.Aug 30, 1922 (Address) 1705 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

20 UNDERTAKER Wm. Easton Be

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67231

CERTIFICATE OF DEATH.

D 67231
1-PLACE OF DEATHCITY OF BALTIMORE: (No. Bay View Hospital
Eastern Ave. WARD)2-FULL NAME Jane Gross(a) RESIDENCE NO. Bay View Asylum WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Black

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?6 DATE OF BIRTH (month, day, and year) 1844

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fredrick, Md
(State or country)10 NAME OF FATHER Henry Smith11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) 11
(State or country)14 Informant Hosp. Records.
(Address)

15

SEP 1 - 1922

ROBERT N. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31 192217 I HEREBY CERTIFY, That I attended deceased from 8-28 1922 to 8-31 1922, that I last saw her alive on 8-31 1922, and that death occurred, on the date stated above, at 2:10 p. m.

The CAUSE OF DEATH* was as follows:

Senile gangrene of right foot

CONTRIBUTORY

(Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -Was there an autopsy? noWhat test confirmed diagnosis? Examination(Signed) J. Richardson Jones M. D.19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

NOVANOVANOVANOVA

DATE OF BURIAL

9-2 1922

ADDRESS

1631 16th StHillmore

Exact statement of OCCUPATION should be supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67232

CERTIFICATE OF DEATH.

D 67232

1-PLACE OF DEATH

City of BALTIMORE: (No. 1232 So. Elwood Ave. St. Ward)

2-FULL NAME

(Residence in Baltimore: No. 1232 So. Elwood Ave. St. yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, Aug 31 1922 (Month) (Day) (Year)

7-AGE, 10 yrs. mos. ds. If LESS than 1 day, 10 hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baeto. md

10-NAME OF FATHER, Max Sereczak 11-BIRTHPLACE OF FATHER, (State or Country), Austria 12-MAIDEN NAME OF MOTHER, Justyna Kopelke 13-BIRTHPLACE OF MOTHER, (State or Country), Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Max Sereczak (Address), 1232 So. Elwood Ave

15-

SEP 1-1922

ROBERT H. KRAUTER,

Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 31 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy, or inquiry, thereon and from the evidence obtained by said Inquest, autopsy, or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed), J. H. Thornton M. D. (Coroner) 1922 (Address), Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal. Baeto. md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus DATE OF BURIAL, Sept 1 1922 ADDRESS, 1618 Eastern Ave

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of occupation state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67233

CERTIFICATE OF DEATH.

113

D 67233

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 N. Stricker ST., 16 WARD)

2. FULL NAME Lois Audrey Bonds

(a) RESIDENCE No. 1111 N. Stricker

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 3

mos. 10

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

3

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

One

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Henry Bonds

11 BIRTHPLACE OF FATHER (city or town)

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Josephine Campbell

13 BIRTHPLACE OF MOTHER (city or town) Dumfries Va. (State or country) Virginia

14

Informant

(Address)

Mrs. Josephine Bonds 1111 N. Stricker St.

15

SEP 1 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1922

17

I HEREBY CERTIFY, That I attended deceased from August 27, 1922, to August 30, 1922.

that I last saw her alive on August 30, 1922,

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home 1111 Stricker St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Frank Saunders, M. D.

19 (Address) 1123 Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Auburn Sept 1, 1922

20 UNDERTAKER ADDRESS

Edward Puggold 1463 N. Carey

ation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67234

CERTIFICATE OF DEATH.

90 D 67234

Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3164 Ravenwood Ave St. 8 Ward.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Elizabeth M. Grimes(Residence in Baltimore: No. 3164 Ravenwood Ave St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE White 5-Single, Married, Widowed, or Divorced Married (Write the word.)6-DATE OF BIRTH. Dec 4 1863
(Month) (Day) (Year)7-AGE. 59 yrs. 8 mos. 26 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) at home9-BIRTHPLACE. (State or Country). Balti Co Md10-NAME OF FATHER Asbury Malesworth11-BIRTHPLACE OF FATHER. (State or Country). Fredrick Co Md12-MAIDEN NAME OF MOTHER. Elizabeth Duffey13-BIRTHPLACE OF MOTHER. (State or Country). Balti Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jerome Grimes
(Address) 3164 Ravenwood Ave

15-

Filed

SEP 1 - 1922

ROBERT N. KALLER
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 30 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon had from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardia - Arteriosclerosis
(Information furnished by Dr M. L. Wagner 3115 E. Baltimore)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. H. Porter M. D.
(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore Cemetery Chest 2nd 1922
ADDRESS 1442Robert Turner Inc 9 Broadway

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Exact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-18-21—M&T—1500 Bks.

D 67235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1429 Bolton ST., 14 WARD)

2-FULL NAME

Annie Nicholson Price

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

1429 Bolton

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

wid

6 DATE OF BIRTH (month, day, and year)

Dec 1845

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Joseph H. Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ann Cox Emory

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Gallie E. Wilmer 1429 Bolton St

15

SEP 1 - 1922

ROBERT R. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1922

17

I HEREBY CERTIFY, That I attended deceased from about June 1st, 1922, to Aug 31st, 1922, that I last saw him alive on Aug 31st, 1922, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder
& secondary carcinoma of liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 20, 1922

Was there an autopsy? No

What test confirmed diagnosis? Microscopic section

(Signed) J. K. B. E. Seegar, M. D.

19 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

MOVAL Centerville Md. Sept 2 1922

UNDERTAKER

ADDRESS

John O. Mitchell 1201 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 7 WARD)2-FULL NAME Lewis Weitzel(a) RESIDENCE No. 507 N. Rose St. ST. 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18577 AGE Years Months Days If LESS than 1 day, hrs. or min. 65 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pottery

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland10 NAME OF FATHER Mike Weitzel11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Josephine Schweinfest13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Hospital Records, (Address) Municipal Hospital15 SEP 1-1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28 192217 I HEREBY CERTIFY, That I attended deceased from August 22, 1922 to August 28, 1922, that I last saw him alive on August 28, 1922, and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. M. Quill M. D. 8/29/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITERS OF THIS FORM SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. D 67237 Municipal Hospital ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lottie Hoy(a) RESIDENCE NO. 1112 School Court ST. 23 WARD 23
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1882 ?
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
About 40 ?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records, UNIVERSITY OF MARYLAND
(Address) Municipal Hospital15 SEP 1 1922 ROBERT H. KRAUTER
Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 19 2217 I HEREBY CERTIFY, That I attended deceased from August 24 19 22, to August 29 19 22.that I last saw her alive on August 28 19 22.and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebro spinal syphilis(duration) 1 yr. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yr. yrs. mos. ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Wass. R.S.F.
(Signed) Alice M. Neil M. D.8/29/22 Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1922
SEP 1 1922

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

✓
ORE D 67238
112

REGISTERED NO

1-PLACE OF DEATH

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST., WARD.

(a) RESIDENCE. No. 817 Tossier Street ST. WARD. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 46 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. d

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30th. 19 22

17 I HEREBY CERTIFY, That I attended deceased from
Aug. 23rd. 1922, to Aug. 30th. 1922.

that I last saw h..... alive on..... Aug. 29th. 1922
and that death occurred, on the date stated above, at..... 3 P. m.
The CAUSE OF DEATH* was as follows:

(a) Trade, profession or particular kind of work

040

(b) General nature of industry, business, or establishment in which employed (or employer) Porter in store

(c) Name of employer **Goodmans Grocery**

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER William Tidings

11 BIRTHPLACE OF FATHER (city or town) A.A. County
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Peck

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Rosa Tidings
(Address) 817 Tensier St., Balto. Md.

13 Filed Robert P. Harrison, Registrar

AP 1-1922

~~MIRIAM FERRER CLARK.~~

Gastritis, Acute

(duration) _____ yrs. _____ mos. 7 d.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. d.

18 Where was disease contracted if not at place of death?

Did an operation precede death? **NO** Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William O. Harris, M. D.

8/30/22 (Address) 1200 Penna. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

Laurel

20 UNDERTAKER DENNIS

203 PRESTMAN ST

HEALTH DEPARTMENT—CITY OF BALTIMORE

67239

(Mamie Golden)

CERTIFICATE OF DEATH.

178 D 67239

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2445 Ething ST.; 14 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2445 Ething St.; 15 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH,

1897 (Month) (Day) (Year)

7-AGE,

25 yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Home Duties

9-BIRTHPLACE,

(State or Country), Virginia

10-NAME OF FATHER,

John Bolden

11-BIRTHPLACE OF FATHER

(State or Country), Virginia

12-MAIDEN NAME OF MOTHER

Minnie Smith

13-BIRTHPLACE OF MOTHER

(State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Maggie Rice (sister)

(Address)

421 Haver St.

15-

Filed

Robert P. Harrison

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug 31, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1922 to Aug 31, 1922

that I saw him alive on Aug 31, 1922

and that death occurred, on the date stated above, at 9:55 AM

The CAUSE OF DEATH* was as follows:

acute nephritis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. E. D. M. D.

191... (Address) 1602 P. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

DATE OF BURIAL,

Sept 2, 1922

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

1922 Burial Permit Clerk.

49 D 67240

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. 0 mos. 0 ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31 19 22

17 I HEREBY CERTIFY, That I attended deceased from
May 22, 1922, to August 31, 1922

that I last saw him alive on August 22, 1926.

and that death occurred on the date stated above at 5:40 P.m.

The CAUSE OF DEATH* was as follows:

THE CAUSE OF PLURALITY WAS AS FOLLOWS:

Resumen (Total)

Reading with the 1900

(duration) yrs. 3 mos. 8 ds.

CONTRIBUTORY Perdomo

(Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted _____

if not at place of death?

Did an operation precede death? No.....Date of

Was there an autopsy?..... No

What test confirmed diagnosis? *W.D. Hospital*

(Signed) Caleb W. Dyer, M. D.

1032 (address) 100 S. Patterson Post and

for, 19- (Address) 3600 V - 2nd Ave NW

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental,

Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL						DATE OF BURIAL

Wrentham Cemetery Sept 2 192

20 UNDERTAKER	ADDRESS
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William Cook Carlisle

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Sept 4 1922

C. Hampson Jones M D
Commissioner of Health
Baltimore Md,

2 6724

This is to certify that the age given on certificate of John W
Payne who died at Mercy Hospital on August 31 1922, as 76 years is incorrect
According to his children the age should be 55 years,

Signed: *Charles J. Foley*

Sept 4, 1922

Mercy Hospital

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HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67241

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mersey St.* ST. *4* WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. Rose Payne

6 DATE OF BIRTH (month, day, and year)

Aug 15 1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

John Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14 Informant (Address)

Mersey St. Records

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 31 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 29 1922 to Aug 31 1922

that I last saw him alive on Aug 31 1922

and that death occurred, on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 7 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 180 Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

BURIAL

ADDRESS

D 67242

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No. *Bay View Hospital* St. *Bay View Hospital*)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1309 Hollins St* - *24* St.; yrs.,..... mos.,..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

*white*5-Single, Married, Widowed, or Divorced. (Write the word.) *Single*

6-DATE OF BIRTH

Oct 25 1897
(Month) (Day) (Year)

7-AGE

24 yrs. *10* mos. *6* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

Home

9-BIRTHPLACE, (State or Country).

Balto.-md

10-NAME OF FATHER

Foster Routzahn

11-BIRTHPLACE OF FATHER, (State or Country)

Frederick. md

12-MAIDEN NAME OF MOTHER

Emma French

13-BIRTHPLACE OF MOTHER, (State or Country).

md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Helen Routzahn
1309 Hollins St

15-

1922

192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Aug 31 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, that I took charge of the

remains described above, held an

Autopsy
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

and that said deceased came to *her* death
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxaemia

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Gangrene Right(Signed) *Wm. H. Horton*
(Coroner)1922 (Address) *Bay View*

*State the Disease Causing Death, or in death from Violence Causes, state (1) Means of Injury; and (2) Place of Injury, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Woods Park**9/2 1922*

20-UNDERTAKER

ADDRESS

*Wm. H. Horton**1309 Hollins St*

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION and state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67243

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 640 N. Baltimore St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lanno, C. Chasow.
(Residence in Baltimore: No. 740 N. Lexington St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced

Married
(Write the word)

6-DATE OF BIRTH

July 6 1861
(Month) (Day) (Year)

7-AGE

61 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER.
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER.
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1922

Robert J. Harrison

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

July 31 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....

find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sudden disease of the Heart
(Duration) about 10 mos. ds.

CONTRIBUTORY (Secondary)

Don't know
(Duration) yrs. mos. ds.

(Signed) H. H. Gorman M. D.
(Coroner.)

9-11 1922 (Address) 117 N. Lexington St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Baltimore County Sept 4, 1922

20-UNDERTAKER. ADDRESS

John F. Denny 715 Light St

D 67244

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67244

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 W Lexington ST. WARD)

2-FULL NAME

Elisabeth Hoerner

(a) RESIDENCE NO.

746 W Lexington St.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? 60 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ernest Hoerner

6 DATE OF BIRTH (month, day, and year)

Feb. 18, 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

85

11

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Rev. C. Merkel 746 W Lexington St.

15

Filed

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1921, to September 1, 1922.

that I last saw him alive on September 1, 1922.

and that death occurred, on the date stated above, at 6 m.

The CAUSE OF DEATH* was as follows:

Sarcoma uterus

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Heumann, M. D.

Address 800 Harlem A

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

BIAL

Immanuel

20 UNDERTAKER

K. Heumann

DATE OF BURIAL

Sept 3 1922

ADDRESS

320 Bond

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

SE 2-1322

Burial Permit 11211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67245

D 67245

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Union Memorial Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

ST.: *27* WARD)

2-FULL NAME

Dora Lollmann

(a) RESIDENCE. NO.

20 Bayonne Ave. Hamilton

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. ☒ mos. ☒ ds. How long in U. S., if of foreign birth? *50* yrs. ☒ mos. ☒ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Fredrick W. Lollman (d)*

6 DATE OF BIRTH (month, day, and year)

1850

7 AGE

72

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Housewife*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Germany*

10 NAME OF FATHER

*Lampe*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*not known*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Germany*

14

Informant
(Address)*Edward Lollmann
20 Bayonne Ave.*

15

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 31 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Aug 31 1922, to Aug 31 1922*that I last saw him alive on *Aug 31 1922*and that death occurred, on the date stated above, at *9* m.

The CAUSE OF DEATH* was as follows:

*Intestinal obstruction (strangulation
of Abdominal Hernia)
Dead immediately after operation*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Abdominal Hernia
Years (duration) yrs. mos. ds.*18 Where was disease contracted
if not at place of death?Did an operation precede death? *Yes* Date of *Aug 31 1922*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Edward M. Harrison, M. D.*, 19 (Address) *Union Memorial Hosp.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Matthews Cemetery Sept 3, 1922

20 UNDERTAKER

ADDRESS

H. Sander Lous 1710 Pled H

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

SEP 2 - 1922

STATE OF MARYLAND, CITY OF BALTIMORE, TO WIT:

I HEREBY CERTIFY, That on this *Sixth* day of October, in the year nineteen hundred and twenty-two, before me, the subscriber, a Notary Public, of the State of Maryland, in and for the City of Baltimore aforesaid, personally appeared Eduard Lollmann, and made oath in due form of law that his mother, Dora H. M. Lollmann, departed this life on the thirty-first day of August, 1922, in the City of Baltimore, at the Union Memorial Hospital, and, furthermore, that her husband, Frederick W. Lollmann, departed this life sometime during the year nineteen hundred and three, whose widow she was at the time of her decease.

AS WITNESS my hand and notarial seal the day and year first above written.

Eduard Lollmann

Francis N. Kieseewetter
Notary Public.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67246

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No 640 S. Curley ST. 1 WARD)

2-FULL NAME Lotta Estella Packham

(a) RESIDENCE NO. 640 S. Carley ST. _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
How long in U. S. if of foreign birth? yrs. _____ mos. _____

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
-------	-----------------	--

Female White Married
5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frederick H. Puckham

6 DATE OF BIRTH (month, day, and year) December 13, 1897

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	24	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) *Baltimore Md*

10 NAME OF FATHER George Biscoe

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER *Anna J. Cunningham*

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) Baltimore Md

14 Informant Frederick H. Packham
(Address) 15055 N. Custer

15 Robert P. Harrison, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1922

17 I HEREBY CERTIFY, That I attended deceased from
Aug 28, 1922, to Aug 30, 1922.
that I last saw her alive on Aug 30, 1922.

and that death occurred, on the date stated above, at 9:38 A. m.

THE LOSS OF DEATHS as follows:

Aortic insufficiency

(duration) yrs. mos. ds

CONTRIBUTORY, (Secondary) *Scrubbed for Chronic Endocarditis*

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Myocardial infarct

(Signed) _____, M. I.

19 (Address) 3015 Ellwood

*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accident Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

Rock Lawn Cemetery 19

20 UNDERTAKER	ADDRESS

✓ Vander's Sons 1710 Flat 3

EP 2 - 1922

Page 11 of 11

D 67247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital, Ward) 23

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Walters.

(Residence in Baltimore: No. 1604 Light St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Married (Write the word.)

6-DATE OF BIRTH, May 15th 1889. (Month) (Day) (Year)

7-AGE, 33 yrs. 3 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer), 037

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS. 10-NAME OF FATHER, Do not know. 11-BIRTHPLACE OF FATHER, (State or Country), Do not know. 12-MAIDEN NAME OF MOTHER, Do not know. 13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Virgil Walters. (brother in law).

(Address), 1731 Thomas Ave.

15- Robert F. Harrison,

Sept 2 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 31st 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Laceration of the brain.
Pistol shot wound in the head.
Suicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) Otto M. Reinhardt (Coroner) Feb. 1st 1922 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

1604 Light St. Aug. 31st 1922.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Western Cemetery Sept 4, 1922

20-UNDERTAKER, ADDRESS

Joseph By for 1600 or North Ave

Every item of information should be carefully supplied. Not shown on state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67248

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67248

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *4700 Fausdale Ave* St., *10* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1427 Webb St.* St.; yrs. *60* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

SEP 2 - 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67249

CERTIFICATE OF DEATH.

REGISTERED No. C

H H D 67249

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 626 S. Bond ST.; 2 WARD)

2-FULL NAME

(Residence in Baltimore: No. 626 S. Bond St.; 18 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH.

Nov 10, 1874.
(Month) (Day) (Year)

7-AGE.

47 yrs., 9 mos., 22 ds.

If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer 040

9-BIRTHPLACE.
(State or Country),

Poland

10-NAME OF FATHER,

Raymond Cierkies

11-BIRTHPLACE OF FATHER
(State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Unkerson

13-BIRTHPLACE OF MOTHER
(State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Cierkies

(Address) 626 S. Bond St.

15-

Filed Robert P. Harrison, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

August 31, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 29, 1922, to August 31, 1922, that I saw him alive on August 31, 1922, and that death occurred, on the date stated above, at 5:40 p.m. The CAUSE OF DEATH* was as follows:

Stomach (Duration) 2 yrs., mos., ds.

CONTRIBUTORY Ex.haustion (Duration) 1 yrs., mos., ds.

(Signed) J. J. Henderson, M. D. Sept. 1, 1922 (Address) 722 S. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Rosary

DATE OF BURIAL,

Sept. 4, 1922

20-UNDERTAKER

John M. Weber

ADDRESS

1803 Park St.

NOTE.—Every item of information should be carefully supplied. AGE, unless otherwise stated, is in years, months, and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2-1922

D. 67250

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 67250

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 574 So. Washington St. Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Leon Novak

(Residence in Baltimore: No. 574 So. Washington St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-Single,

Married,

Widowed,

or Divorced,

(Write the word.)

Single

6-DATE OF BIRTH,

Aug 18

1922

(Month) (Day) (Year)

7-AGE,

94

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE,
(State or Country).

Balto. Md

PARENTS.

10-NAME OF FATHER,

Walter Novak

11-BIRTHPLACE OF FATHER,
(State or Country).

Balto Md

12-MAIDEN NAME OF MOTHER,

Rosie Strzelecki

13-BIRTHPLACE OF MOTHER,
(State or Country).

Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Walter Novak

(Address)

574 So. Washington St.

15-

Robert P. Harris

IP2

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 1st

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY That I took charge of the

remains described above, held an

(Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said

(Inquest, autopsy or Inquiry.)

find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Indigestion

(Duration)

12 hours

CONTRIBUTORY

(Secondary)

(Duration)

yrs. mos. ds.

(Signed)

J. B. Norton

(Coroner.)

(Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

Homicidal

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. State, yrs. mos. ds.

In the

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Stanislaus Sep 2 1922

20-UNDERTAKER, ADDRESS

John M. Weber 1803 Bank

NB.—Every item of information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2-1922

D. 67251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 67251

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Oakhurst Place ST., 16 WARD)

2-FULL NAME James Kelly Smith

(a) RESIDENCE NO. 1209 Oakhurst Place ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 6th 19187 AGE Years Months Days If LESS than 1 day, hrs. or min.
4 1 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER Joseph P. Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)14 Informant Joseph P. Smith
(Address) 1209 Oakhurst Place

15 Filed Robert F. Harrison, 19 Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 31st 19 2217 I HEREBY CERTIFY, That I attended deceased from Aug 27th 19 22, to Aug 31st 19 22, that I last saw him alive on Aug 31st 19 22, and that death occurred, on the date stated above, at 10.30 P.m.
The CAUSE OF DEATH* was as follows:

Ileo-colitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. S. Jones, M. D.

9/1 19 22 Address 120 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cem

DATE OF BURIAL

Sept 2nd 19 22

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 1/2 Bells

St

B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 933 Kenma One St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary V. Stouden

(Residence in Baltimore: No. 9330 Emma Ave. St.; yrs., 60 mos. 00 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

CORONER'S CERTIFICATE OF DEATH

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-Single, *Married*, *Widowed*, *or Divorced*, *(Write the word.)*

6-DATE OF BIRTH. April 1885
(Month) (Day) (Year)

7-AGE, 65 yrs. mos. ds. hrs. or min. If LESS than 1 day

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer). *110*

9-BIRTHPLACE,
(State or Country).

10-NAME OF FATHER. 5

11-BIRTHPLACE
OF FATHER,
(State or Country).

12-MAIDEN NAME
OF MOTHER.

13-BIRTHPLACE
OF MOTHER,
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Campbell

(Address).....1114 Geneva, NY.

13- _____

1981 1992

16-DATE OF DEATH, August 31, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an..... *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au.....
.....and that said deceased came to her death
topsy or inquiry.)
on the day stated above. 6

The CAUSE OF DEATH* was as follows:

Celestial Keweenaw.

..... (Duration) yrs. mos. 2 ds

CONTRIBUTORY *no history.*
(Secondary)

..... (Duration) yrs. mos. ds

(Signed) J. E. Hemmery, M. D.
(Coroner)

Sept 1, 1922 (Address) 272 Cadman Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19	PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
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456

19

20-UNDERTAKER, ADDRESS C /

Amal Singh 17/2/68

Every item of information should be carefully supplied. AGE SHOULD BE STATED EXACTLY. STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 67253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *On boat to C. + A. Coming to Balt.*)

REGISTERED NO. C

WARD *18*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Carmi Sampell*(Residence in Baltimore: No. *828 Saratoga*)St.; yrs., *6* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *Col.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *1*

(Month)

(Day)

(Year)

7-AGE, *27*

yrs.

mos.

ds.

If LESS than 1 day,

... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *037*9-BIRTHPLACE, (State or Country), *Va.*

PARENTS.

10-NAME OF FATHER, *Not known*11-BIRTHPLACE OF FATHER (State or Country), *Not known*12-MAIDEN NAME OF MOTHER, *Not known*13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Samuel Eason*(Address) *916 D.C. Ave.*

15-

Robert P. Harrison

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 1*, 19*22*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-topsy or inquiry.) and that said deceased came to *the* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. Disease Heart.
Myocarditis
(Duration) *1* yrs. *6* mos. *6* ds.CONTRIBUTORY (Secondary) *Not known*(Duration) *1* yrs. *6* mos. *6* ds.(Signed) *Samuel Eason*

(Coroner)

M. D.

Sept 1, 19*22* (Address) *916 D.C. Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *Not known* in the *1* yrs. *6* mos. *6* ds. State *1* yrs. *6* mos. *6* ds.Where was disease contracted, if not at place of death? *Not known*Former or usual residence *Not known*

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, *Sept 2*, 19*22*20-UNDERTAKER *Samuel Eason*ADDRESS *916*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S MORTUARY STATEMENT OF DEATH IN PLAIN TERMS, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67254

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5) St. 5 Ward

2-FULL NAME

(Residence in Baltimore: No. 401 Forrest St.; yrs. mos. ds.)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-Single,
Married,
Widowed,
or Divorced.
(Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

22

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER,
(State or Country).12-MAIDEN NAME
OF MOTHER,15-BIRTHPLACE
OF MOTHER,
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP 2-1922

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquiry find that said deceased came to death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Pistol shot in rt temple
self inflicted, probably
accidentalCONTRIBUTORY
(Secondary)

(Signed)

9-11-1922

(Coroner)

1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

D 67255

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME

Barbara Marshall

(a) RESIDENCE NO.

1120 E. Monument St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ralph Marshall

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

19

Harrison

Registrar

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 8-22, 1922, to 8-29, 1922.

that I last saw him alive on 8-29, 1922.

and that death occurred, on the date stated above, at 9:40 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary & Meningeal Tuberculosis

CONTRIBUTORY (Secondary) Cardiac Failure (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

19

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

88-1922

Cremated

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67256

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *S. Baltimore General Hospital* ST. *14* WARD)

2. FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Robert P. Harrison

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *2nd Sep* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *1st Sep*, 19*22*, to *2 Sep*, 19*22*.that I last saw her alive on *2 Sep*, 19*22*.and that death occurred, on the date stated above, at *200 A. m.*

The CAUSE OF DEATH was as follows:

Haemorrhage - Ectopic Gestation (4 hrs. illness)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

2 Sep 1922 (Address) *Linthicum Heights Md*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*George Schelling & Sons**1126 E. Mount*

—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

261-2 JJS

D 67257

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67257

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed SEP 9 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Compression of umbilical Cord during Birth

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horace B. Titlow, M.D.

Address 315 S. Highland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

20 UNDERTAKER

Lilly W. Zule

DATE OF BURIAL

Sept. 7th 1922

ADDRESS

4038 Moller

N.B.—WRITE DATE, TIME, AND PLACE OF DEATH, EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

SEP 3 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Aug 1st 1922 to Sept. 2nd 1922, that I last saw him alive on Sept. 2nd 1922, and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Georgia

Did an operation precede death? Yes Date of August 3, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? (Signed) Warfield W. Jones M. D.

2, 1922 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

Waycross Ga

20 UNDERTAKER

John O. Mitchell 128 W Fayette

DATE OF BURIAL

Sep 2 1922

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS IMPORTANT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

67260

HEALTH DEPARTMENT—CITY OF BALTIMORE

67260

D 67260

CERTIFICATE OF DEATH.

D 67260

1-PLACE OF DEATH

Intre Dame
Gorans. Mt.

3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.,

WARD)

2-FULL NAME

Alfredo Maddalo

(a) RESIDENCE NO.

236 S. Exeter St.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (Write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 21, 1921

7 AGE

— Years 9 Months 11 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. City

10 NAME OF FATHER

Ettore Maddalo

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Maria Carizzo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Ettore Maddalo
236 S. Exeter St.

15

SEP 3 - 1922

ROBERT H. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 20, 1922, to Sept. 2, 1922,

that I last saw him alive on Sept. 1, 1922,

and that death occurred, on the date stated above, at 7:10 a. m.

The CAUSE OF DEATH* was as follows:

Pneumo-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Whooping Cough (?)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

at 236 S. Exeter St.

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

lung findings & from

(Signed) Charles O. Davidson, M. D.

(Address) 6 E. Lomb St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Holy Redeemer Ch

9/4/22

20 UNDER TAKER

ADDRESS

Geo. J. Puth 1735 Howard

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67261

CERTIFICATE OF DEATH.

D 67261

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 326 Patapsco Ave ST. 10 WARD)

2-FULL NAME

Caroline Curry

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

326 Patapsco Ave

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Curry6 DATE OF BIRTH (month, day, and year) June 19 18877 AGE Years Months Days If LESS than 1 day, hrs. or min. 85 2 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md.

10 NAME OF FATHER

George Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant

(Address)

Clara E. Kalishman
326 Patapsco Ave

15

SEP 3 - 1922

ROBERT A. KRANTZ
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 1, 1922, to Aug 29, 1922,that I last saw him alive on Aug 31, 1922,and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) A. W. Keiser, M. D.8/31, 1922 (Address) 1 Kinship Rd. Dundalk Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Carmel Cemetery Sept 4 192220 UNDERTAKER ADDRESS 203Henry Lutz N. Broadway

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67262

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *512 N Monroe St.* ST. *20* WARD)

2. FULL NAME

Chas D Stierhoff

(a) RESIDENCE NO.

512 N Monroe St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 16, 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*3**4**16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Chas D Stierhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Barnetta Maroney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant

(Address)

Chas D Stierhoff
512 N. Monroe St.

15

SEP 3 - 1922

ROBERT H. KRAIDER
Registrar

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Aug 31 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Aug 31, 1922, to Aug 31, 1922*that I last saw him live on *Aug 31, 1922*

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication
(Plumaine poison)

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edw J Coolahan*, M. D.*9/2/22* Address *24 N Tuxton Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park**Sept 4 1922*

20 UNDERTAKER

ADDRESS

Isaac Fields 1200 W Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67263

CERTIFICATE OF DEATH.

D 67263

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 81 Darby

ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Viola Howard

(a) RESIDENCE. No. 81 Darby

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of Charles E. Howard (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28 1894

7 AGE Years 28 Months 3 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Ely Campbell

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Amos

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Charles Howard (Address) 81 Darby St.

15 Filed SEP 3 1922 ROBERT A. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from August 12, 1922 to Sept. 1, 1922 that I last saw her alive on Sept. 1, 1922, and that death occurred, on the date stated above, at 1:40 P.m. The CAUSE OF DEATH* was as follows:

Eclampsia (menic)

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY Acute Nephritis - Hyperemesis (Secondary) Gravidam (duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank H. Maclean, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Forest Hill Harford Sep 4 1922

20 UNDERTAKER ADDRESS

Chenoweth Son Chestnut Ave

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67264

CERTIFICATE OF DEATH.

113 D 67264

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 271 Hopkins Ave. 13 WARD)

2-FULL NAME Rayburn Wesley Clayton Calk

(a) RESIDENCE. NO. 271 Hopkins Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Jan 11-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Marian Calk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Florence Phelphs

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Henry Ashby, 271 Hopkins Ave. City

15

File

SEP 5 - 1922

ROBERT A. WEAVER, Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 - 1922

17

HEREBY CERTIFY, That I attended deceased from

Aug 30 - 1922, to Sept 1, 1922

that I last saw him alive on Aug 31 - 1922

and that death occurred, on the date stated above, at 1 9

The CAUSE OF DEATH* was as follows:

Convulsions

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Fetus Colitis & Peritonitis

18 Where was disease contracted

if not at place of death?

(duration) yrs. mos. ds.

271 Hopkins Ave

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

no tests

(Signed)

E. E. Nichols, M. D.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Reisterstown Cem Sep 3 1922

20 UNDERTAKER

Chenoweth Son Chestnut Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 EKS.

D 67265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 Jefferson

2-FULL NAME

(a) RESIDENCE. No. 1212 Jefferson

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds.

ST. 5 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 5 WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Esq. Esq.

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Robert H. Gattimer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

and

12 MAIDEN NAME OF MOTHER

Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Edith Green 1212 Jefferson St

15

SEP 3 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1, 1922

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to Sept. 1, 1922.

that I last saw him alive on Sept. 1, 1922.

and that death occurred, on the date stated above, at 2-15 P. M.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

(Address) 1201 Asquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel

ADDRESS

20 UNDERTAKER

Samuel Wright

D 67266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 67266

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Municipal Free Hosp* ST. *5* WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

105 N. Front ST.

WARD

(If non-resident give city or town and State)

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

SEP 3 - 1922

ROBERT R. KRAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from
Aug 17, 19 *22*, *Sept 2*, 19 *22*,
that I last saw her alive on *Sept 2*, 19 *22*,
and that death occurred, on the date stated above, at *3:05* p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *1* yrs. *1* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67267

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1102 S. Sheeper* ST. *1* WARD)

2-FULL NAME

Alfon. Ole(a) RESIDENCE. NO. *1102 S. Sheeper* ST. *1* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 30-1918*7 AGE Years *3* Months *11* Days *13* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *Jacob. Ole*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Poland*12 MAIDEN NAME OF MOTHER *Mary. Mankowski*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Poland*14 Informant *Mary. Ole* (Address) *1102 S. Sheeper*15 Filed *2261-835* *ROBERT R. KRAUTER*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 2* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Aug 29 19 *22*, to *Sept 2* 19 *22*,that I last saw him alive on *Sept 1* 19 *22*,and that death occurred, on the date stated above, at *7:45 a.m.*

The CAUSE OF DEATH* was as follows:

*accidental Burns by falling in hot water*CONTRIBUTORY (Secondary) *Sept 2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *James J. Roney, M. D.**9/2, 1922* (Address) *539 S. Ellwood Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

S. J. Fialkowski *Sept 4* 19 *22*

ADDRESS

W. J. Hamsburg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PUBLIC RECORD. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67269
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3537 Hickory Ave. ST. 13 WARD)

2-FULL NAME

(a) RESIDENCE No. 3537 Hickory Ave. ST. 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

1 SEX 2 COLOR OR RACE 3 Single, Married, Widowed, Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

SEP 3 - 1922

ROBERT A. MAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1922

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1922, to Sept 1, 1922, that I last saw her alive on Sept 1, 1922

and that death occurred, on the date stated above, at 10:45 A. M.

The CAUSE OF DEATH* was as follows:

Epilepsy - Lethargia
(See remarks)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptomatic (Signed) R. B. Norman, M. D.

(Address) 3547 Chesnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

St. Mary's (Hampton) Sept. 4 1922

UNDERTAKER

ADDRESS

Horace A. Burgee 3631 Fells Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY, AGE should be carefully supplied. Exact statement of OCCUPATION should be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67270

CERTIFICATE OF DEATH.

D 67270

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 East 33rd ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Estelle Warfield(a) RESIDENCE. NO. 8130 East 33rd ST.: 9 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred lys yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Thomas Warfield6 DATE OF BIRTH (month, day, and year) March 14-18727 AGE Years 50 Months 5 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balti city. (State or country)10 NAME OF FATHER George W. Shuler11 BIRTHPLACE OF FATHER (city or town) Balti. (State or country)12 MAIDEN NAME OF MOTHER Eleanora Williams13 BIRTHPLACE OF MOTHER (city or town) Balti. (State or country)14 Informant Mrs. George T. Warfield (Address) 813 East 33rd St.15 Filed SEP 3 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 192217 I HEREBY CERTIFY, That I attended deceased from Aug, 1921, to Sept 2, 1922, that I last saw h. ex. alive on Sept 2, 1922, and that death occurred, on the date stated above, at 11:20 A.m. The CAUSE OF DEATH* was as follows:Pulmonary Tuberculosis(duration) 4 yrs. ? mos. - ds.

CONTRIBUTORY (Secondary)

Myocarditis (duration) 12 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Sputum exam.(Signed) Louis F. Brannen, M. D.19 (Address) 722 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm Cook502 E North

HEALTH DEPARTMENT—CITY OF BALTIMORE

67271

CERTIFICATE OF DEATH.

31

D 67271

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 Raleny, ST.; 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 724 Raleny St.; 5 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)

6-DATE OF BIRTH,

May, 1, 1887
(Month) (Day) (Year)

7-AGE

35 yrs., mos., ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Laundress
(b) General nature of industry, business, or establishment in which employed (or employer), Self

9-BIRTHPLACE, (State or Country),

MD.

10-NAME OF FATHER

Moses Brown

11-BIRTHPLACE OF FATHER (State or Country),

MD.

12-MAIDEN NAME OF MOTHER

Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country),

MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Smith

(Address) 724 Raleny St.

15-

File SEP 3 1922 ROBERT B. KRAUTER Registrar.

Daryl Pomeroy Clark

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug, 31, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1 1922, to Aug 31 1922,

that I saw him alive on Aug 31 1922,

and that death occurred, on the date stated above, at 11:15 PM.

The CAUSE OF DEATH* was as follows:

Influenza

.....

.....

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aspiration

..... (Duration) yrs. mos. ds.

(Signed) Dr. J. H. Smith M. D.

Sept 2 1922 (Address) 712 S. Mary

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

.....

.....

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laurel Hill Sept 4, 1922

20-UNDERTAKER ADDRESS Brown, Treland, Schermer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67272

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Pine

ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Walker

(Residence in Baltimore: No. 407 N. Pine

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Aug. 1860
(Month) (Day) (Year)

7-AGE,

62

yrs., mos., ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress 041
Home work

9-BIRTHPLACE, (State or Country),

Centerville Md

10-NAME OF FATHER,

Charles Wilson

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Ma.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Josephine Gross

(Address) 407 N. Pine St

15-

Filed

SEP 3 - 1922

ROBERT R. KRAUTER

Baltimore

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Aug. 30, 1922.
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from July 20th 1922, to July 29th 1922, that I saw him alive on July 27th 1922, and that death occurred, on the date stated above, 9:00 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. 20 ds.

(Signed) A. L. C. M. D.

9/1, 1922 (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lester Cemetery

Sept. 13 1922

20-UNDERTAKER

ADDRESS

Lester Cemetery

578 Bedale

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
causes of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 67273

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 67273

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 258 1/2 S Dulles St. 3 WARD)

2-FULL NAME

(a) RESIDENCE. No. 258 1/2 S Dulles St.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 15 1921

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

1

3

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

none

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Nikolaj Gwiazdowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Helie Legen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Poland

14

Informant
(Address)

Nikolaj Gwiazdowski
258 1/2 S Dulles St.

15

File

SEP 3 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 2 22

17

I HEREBY CERTIFY, That I attended deceased from
Aug 27, 1922, to Sept 2, 1922,
that I last saw him live on Sept 2, 1922,
and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

acute Abdominal crisis

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 22 Address

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

1006 Rosary St

Dec 4 1922

20 UNDERTAKER

ADDRESS

John M. Weber

1803 Bank St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67274

D 67274

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE (No. *5311 Ethelbert* St. *27* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *5311 Ethelbert* St.; yrs.,..... mos.,..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*

4-COLOR OR RACE, *White*

5-MARITAL STATUS, *Single*
Married,
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH, *Jan 18 1912*

7-AGE, *10* yrs.,..... mos.,..... ds.

If LESS than 1 day, hrs., or, min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) *Baltimore Maryland*

10-NAME OF FATHER *E. E. Gardner*

11-BIRTHPLACE OF FATHER (State or Country) *Cambridge Md*

12-MAIDEN NAME OF MOTHER *Marion J. Blythe*

13-BIRTHPLACE OF MOTHER (State or Country) *New York*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Signature) *Marion J. Gardner*
(Address) *5311 Ethelbert St.*

15-

Filed

SEP 3 - 1922

ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 1 1922*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said... find that said deceased came to death... (opsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary).....

(Signed) *J. H. Morrissey*

(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs.,..... mos.,..... ds. In the State..... yrs.,..... mos.,..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Woodlawn*

DATE OF BURIAL, *Sept 4th 1922*

20-UNDERTAKER, *William Cook*

ADDRESS, *30 St. 18th*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67275

CERTIFICATE OF DEATH.

57

D 67275

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 Poplar ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dorothy Anna Howard

(a) RESIDENCE. NO.

504 Poplar Grove

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1907.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

14

11

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

John H. Howard

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore County

12 MAIDEN NAME OF MOTHER

Catherine W. Rodenwick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Maryland

14

Informant

(Address)

Mrs. Howard

504 Poplar Grove St

15

SEP 3 - 1922

ROBERT N. KRAUER

Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 30, 1922, to Aug 31, 1922

that I last saw him alive on Aug 31, 1922

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Histology & Laboratory

(Signed) Joseph H. Zierler, M. D.

(Address) 1123 Poplar St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Linden Park

DATE OF BURIAL

Sept 4/22

20 UNDERTAKER

Wm. Beck

ADDRESS

502 E. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67276

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1304 Beason St. St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Anna M. Crowther.

(Residence in Baltimore: No. 1304 Beason St. St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female. 4-COLOR OR RACE. White. 5-Single, Married, Widowed, or Divorced. Married (Write the word.)

6-DATE OF BIRTH. August 15th, 1898. 1 (Month) (Day) (Year)

7-AGE. 24 yrs. 18 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Westernport, Md.

10-NAME OF FATHER. George Jonoscha.

11-BIRTHPLACE OF FATHER. (State or Country). Germany.

12-MAIDEN NAME OF MOTHER. Catherine Effenacker.

13-BIRTHPLACE OF MOTHER. (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin Crowther. (husband)

(Address) 1304 Beason St.

15-SEP 4 - 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 2nd, 1922. 192 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above. The CAUSE OF DEATH* was as follows:

Cobar Pneumonia.

CONTRIBUTORY (Secondary) Abortion, non criminal.

(Signature) Otto W. Reinhardt, M. D. (Coroner.)

Address 1017 Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL (OR REMOVAL). DATE OF BURIAL.

20-UNDERTAKER. ADDRESS.

Horace F. Burgee 3631 Fall Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co. 1005 Hka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67277

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hosp* ST.: *6* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *1707 E. Fairmount Ave* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. *10* mos. *14* ds. How long in U. S., if of foreign birth? yrs. *10* mos. *14* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 21 - 1912*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *10 74*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)

10 NAME OF FATHER *Joseph Krantzky*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore Md* (State or country)

12 MAIDEN NAME OF MOTHER *Goldie Greenfield*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md* (State or country)

14 Informant *Hosp Records* (Address)

15 *SEP 4 - 1922* *ROBERT R. KRAUTER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) *Sept. 3, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Aug. 3, 1922* to *Sept. 3, 1922*, that last saw him alive on *Sept. 3, 1922*, and that death occurred, on the date stated above, at *6.40 p. m.*

The CAUSE OF DEATH* was as follows: *Acute Intestinal Indigestion*

(duration) yrs. *1* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at above residence*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *none*

(Signed) *Isidore J. Jure* M. D.

(Address) *Hebrew Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hebrew Mt Carmel *9-4 1922*

20 UNDERTAKER ADDRESS

Jack Lewis 1439 E. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67278

CERTIFICATE OF DEATH.

REGISTERED NO.

D 67278

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *11*)

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

55 yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm. N. Brewer

6 DATE OF BIRTH (month, day, and year)

July 31-1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5-6

1

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Frederick Koerber

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Wm. N. Brewer
Park Ave Brighton Md

15

SEP 4 - 1922

ROBERT R. KRAUTER,

Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1st, 1922, to Sept 2nd, 1922that I last saw her alive on Sept 2nd, 1922

and that death occurred, on the date stated above, at 7:05 a.m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Surgical Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Residence

Did an operation precede death? Yes. Date of 9-1-22

Was there an autopsy?

No

What test confirmed diagnosis?

Physic

(Signed) W. J. Coleman, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oaklawn Cem

Sept 5 1922

20 UNDERTAKER

ADDRESS

W. J. Coleman

NKP

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

158178
D 67279

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced

HUSBAND of

WIFE of
Leonard + Viola Burrs.

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town; State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town; State or country)

PARENTS

14

Informant (Address)

15

SEP 4 - 1922

ROBERT H. KRAUHEN,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to Sept 3, 1922,

that I last saw him alive on Sept 3, 1922,

and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity

CONTRIBUTORY (Secondary)

Malnutrition

(duration) yrs. mos. Lfes. ds.

(duration) yrs. mos. Lfes. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horton Casparian, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

May's Cemetery

ADDRESS

20 UNDERTAKER

W. C. Brooks & Son

Sparks Md

N. B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Ika.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67280

CERTIFICATE OF DEATH.

113 D 67280

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 Penlney Ave ST.: 9 WARD)

2-FULL NAME Benson Corrode Byer

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 713 Penlney Ave ST.: _____ WARD. _____
(Usual place of abode)

Length of residence in city or town where death occurred 1 yr. mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) January 8/11

7 AGE Years 7 Months 10 Days 10 If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) off

(c) Name of employer _____

9 BIRTHPLACE (city or town) Balto (State or country) MD

10 NAME OF FATHER John W. Byer

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) MD

12 MAIDEN NAME OF MOTHER Bessie Thimer

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) MD

14 Informant (Address) John W Byer
712 Penlney Ave

15 Filed SEP 4 1922 ROBERT H. KRAUTER
Registrar
Death Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug 15 19 22, to Sept 2nd 19 22.

that I last saw him alive on Sept 2nd 19 22.

and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. _____ mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Walter D. M. D.

(Address) 401 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon

DATE OF BURIAL

20 UNDERTAKER Wm Cook

ADDRESS

502 E North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67281

CERTIFICATE OF DEATH.

D 67281

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 E Hayward Ave)

2-FULL NAME

(a) RESIDENCE. NO. 15 E Hayward Ave

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza B. Sullivan

6 DATE OF BIRTH (month, day, and year) Oct 30 1873

7 AGE

49

4

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

SEP 4 - 1922

ROBERT A. KRAUTH

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 10 1922

17 I HEREBY CERTIFY, That attended deceased from Mr. 10, 1922, to Aug 10, 1922

that I last saw him alive on Aug 10, 1922

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

UNDERGROUND

ADDRESS

PHYSICIANS, should state state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Dr. G. Walker / E. Burke

MARGIN RESERVATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67282

HEALTH DEPARTMENT—CITY OF BALTIMORE

67282

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 S. Belvidere Ave ST., 1 WARD)

2. FULL NAME

Margaret A. Fischer

(a) RESIDENCE NO.

511 S. Belvidere Ave ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. Now long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 18, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George W. C. Fischer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Mary M. Burmeister

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

George W. C. Fischer
511 S. Belvidere Ave

15

SEP 4 - 1922

ROBERT A. KRAUTER

Public Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

August 20, 1922, to Sept 3, 1922.

that I last saw her alive on Sept 2, 1922.

and that death occurred, on the date stated above, at 2:20 A. m.

The CAUSE OF DEATH* was as follows:

Mononucleosis
Inability to assimilate food

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) Robert A. Krauter, M. D.

1/3, 1922 (Address) Mononucleosis Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

St Pauls Bur.

20 UNDERTAKER

H. Sander Sons

DATE OF BURIAL

Sept 4, 1922

ADDRESS

170 N. Mt. St.

D 67283

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D 67283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 Druid Hill a ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy M. Perry

(a) RESIDENCE. NO. 2029 Druid Hill ST.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

(or) WIFE of

Geo. W. Perry

6 DATE OF BIRTH (month, day, and year) 7/1/1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Rev. Bragg

9 BIRTHPLACE (city or town) (State or country)

Md. Unknown

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Cornelia Spriggs 2029 Druid Hill St.

SEP 4 - 1922

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/1/22

17

I HEREBY CERTIFY, That I attended deceased from

7/1/22 to 9/1/22

that I last saw him alive on 8/31/22

and that death occurred, on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH* was as follows:

an fatal - in tumor of Carcinoma of stomach & liver

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. W. R. Smith, M. D.

9/2, 1922 (Address) 213, 1st St. N. W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

Address

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67284

HEALTH DEPARTMENT—CITY OF BALTIMORE 67284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *President Hospital 16* WARD)

2-FULL NAME

(a) RESIDENCE No. *1010 N. Carey*

(Usual place of abode)

Length of residence in city or town where death occurred

26 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown 1896*

7 AGE

26

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File *SE-4-1922*

Robert A. Krauter

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 1-1922*

17

I HEREBY CERTIFY, That I attended deceased from *July 29, 1922* to *Sept 1-1922*, that I last saw her alive on *Sept 1-1922*

and that death occurred, on the date stated above, at *5:15 P.M.*

The CAUSE OF DEATH* was as follows:

Myocardial Infarction of the heart

CONTRIBUTORY (Secondary)

acute dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *no*

(Signed) *Marcellus E. Jones*, M. D.

, 19 (Address) *1449 N. Carey*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

NOVA
St. Anthony's Cem.

20 UNDERTAKER

Samuel H. Hensley

DATE OF BURIAL

Sept 4, 1922

ADDRESS

1449 N. Carey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67285		(Ella Brown)		D 67285	
HEALTH DEPARTMENT—CITY OF BALTIMORE					
CERTIFICATE OF DEATH.					
1-PLACE OF DEATH					
City of BALTIMORE: (No. <i>University Hospital</i> St. <i>17</i> Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)					
2-FULL NAME <i>Ella Brown</i>					
(Residence in Baltimore: No. <i>650 W. Mulberry St.</i> St.; yrs. mos. <i>2</i> ds.)					
PERSONAL AND STATISTICAL PARTICULARS.					
3-SEX <i>Female</i>		4-COLOR OR RACE <i>Colored</i>		5-Single, Married, Widowed, or Divorced. <i>Single</i> (Write the word.)	
6-DATE OF BIRTH <i>Don't Know</i> (Month) (Day) (Year)					
7-AGE <i>22</i> yrs. mos. ds. If LESS than 1 day, hrs. or min.?					
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Housewife</i> (b) General nature of industry, business, or establishment in which employed (or employer)					
9-BIRTHPLACE. (State or Country). <i>Harrisburg Pa.</i>					
PARENTS.	10-NAME OF FATHER. <i>Don't Know</i>				
	11-BIRTHPLACE OF FATHER. (State or Country). <i>"</i>				
	12-MAIDEN NAME OF MOTHER. <i>"</i>				
	13-BIRTHPLACE OF MOTHER. (State or Country). <i>"</i>				
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Robert H. Maister</i> (Address) <i>650 W. Mulberry St.</i>					
15- <i>SEP 4 - 1922</i> ROBERT H. MAISTER, Clerk. <i>Bertal Perhill</i> , Registrar.					
CORONER'S CERTIFICATE OF DEATH.					
16-DATE OF DEATH. <i>Sept 3</i> , 192 <i>2</i> . (Month) (Day) (Year)					
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said and that said deceased came to <i>her</i> death <i>on the day stated above.</i> (Inquest, autopsy or inquiry.) The CAUSE OF DEATH* was as follows: <i>Carbolic Acid Poisoning</i> (Duration) <i>4 hrs.</i> yrs. mos. ds.					
CONTRIBUTORY (Secondary) <i>Probably Suicide</i> (Duration) <i>4 hrs.</i> yrs. mos. ds.					
(Signed) <i>N. H. Gonsoult</i> M. D. (Coroner.)					
9-4, 192 <i>2</i> (Address) <i>117 W. Annapolis</i>					
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.					
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.					
Where was disease contracted, if not at place of death?					
Former or usual residence					
PLACE OF BURIAL OR REMOVAL <i>Crown Hill</i> DATE OF BURIAL <i>Sept 4</i> 192 <i>2</i>					
UNDERTAKER <i>Sam H. Pleasant</i> ADDRESS <i>403 Mosher</i>					

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH CARE FOR THE FOLLOWING:

D 67286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 67286

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hospital* Ward) *3*

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Walter Bankowski*

(Residence in Baltimore: No. *1504 Eastern Ave* St.; yrs.,..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married* (Write the word.)

6-DATE OF BIRTH *Aug 11* 1922 (Month) (Day) (Year)

7-AGE, yrs. mos. *25* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *none* (b) General nature of industry, business, or establishment in which employed (or employer) *000*

9-BIRTHPLACE, (State or Country), *Balto Md*

PARENTS. 10-NAME OF FATHER, *Walter Bankowski* 11-BIRTHPLACE OF FATHER, (State or Country), *Balto Md* 12-MAIDEN NAME OF MOTHER, *Elizabeth Amant* 13-BIRTHPLACE OF MOTHER, (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Andrew Amant Pencil*

(Address) *1815 Thames St*

15- *HUBERT K. [illegible]*

Filed *SEP 4 - 1922* *Doris P. [illegible]* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 2* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Innumera
(Confirmed by *Dr. Martin*)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Accidents - following Entail*
(Signed) *J. S. [illegible]* M. D. (Coroner) *9-2-22* 1922 (Address) *508 E. North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cath Lawn Cemetery *Sept 4* 1922

20-UNDERTAKER, ADDRESS

Lilly & Zeller *403 S. Wolfe St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—ISC/Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67287

CERTIFICATE OF DEATH.

31 D 67287

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1104 N. Bradford ST., 8 WARD)

2-FULL NAME George F. M^cQuaid

(a) RESIDENCE No. 612 N. Lakewood Ave. ST. 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella G. M^cQuaid

6 DATE OF BIRTH (month, day, and year) April 20 1895

7 AGE Years 27 Months 4 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Vincent M. McQuaid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Maggie Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Ella G. M^cQuaid (Address) 1104 N. Bradford St.

15 SEP 4 - 1922 ROBERT R. MAUTER

Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 1922 to Sept 2 1922 that I last saw him live on Sept 2 1922 and that death occurred, on the date stated above, at 5:45 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction
Septic - Pulmonary
Subcutaneous

(duration) yrs. 16 mos. ds.

CONTRIBUTORY (Secondary) acute edema lungs

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? finding

(Signed) Fred R. Russell M. D.

19-22 Address 800 N. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Patrick's Church

20 UNDERTAKER

Geo. M. Fink & Son

DATE OF BURIAL

Sept 5 1922

ADDRESS

811 N. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67288

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 628 Stripper ST., 1 WARD)

2. FULL NAME Wladyslaw Struzik

(a) RESIDENCE NO. 628 Stripper ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 29 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Adam Struzik

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Margaret Akman

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Adam Struzik (Address) 628 Stripper St.

15 SEP 4 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1922, to Sept 3, 1922.

that I last saw him alive on Sept 3, 1922.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

congenital Aortic Heart

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. N. Otter, M. D.

(Address) 1008 Potomac Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Rosary

4 1922

20 UNDERTAKER

ADDRESS

John Weber

1843 Bank

ROBERT A. WEBSTER

D 67239 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

172 D 67285

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *white* 5-SINGLE, *?* MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *unknown*, 1 (Month) (Day) (Year)

7-AGE, *62* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Coal miner* (b) General nature of industry, business, or establishment in which employed (or employer), *086*

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 4 - 1922

ROBERT R. WADSWORTH

Filed

Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 4*, 191*1* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *death* (Inquest, au- topsy or inquiry.)

on the day stated above. The CAUSE OF DEATH* was as follows:

Heart attack caused by
fatigue or overwork from
work at 1427 N. Charles St. N. Charles
St. N. Charles St. N. Charles St.
insane - (Baltimore) (Baltimore) (Baltimore)

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. J. ...* M. D.

Sept 2, 191*2*. (Address) *1659 Ave ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *5 minutes* In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Coddale N. Va.

DATE OF BURIAL,

Sept 5, 19*22*

20-UNDERTAKER

Edw. J. Fanning Hon Wm. St. Lafayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67290

CERTIFICATE OF DEATH.

REGISTERED NO.

D 67290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *401 Belvoir Ave* ST. *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Allen Nelson Wilson*(a) RESIDENCE. No. *401 Belvoir Ave* ST. *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed or divorced HUSBAND of *Clara Quoniam Wilson*6 DATE OF BIRTH (month, day, and year) *July 20-1889*7 AGE Years *83* Months *1* Days *13* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired 086*(b) General nature of industry, business, or establishment in which employed (or employer) *Pattern Maker*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*19 NAME OF FATHER *George Wilson*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Rachel Todd*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Maryland*14 Informant *Miss Clara Wilson* (Address) *401 Belvoir Ave*15 Filed *SEP 4 1922* ROBERT R. KRAUTER, *Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 2 1922*17 I HEREBY CERTIFY, That I attended deceased from *Aug. 14*, 19*22*, to *Sept. 2*, 19*22*, that I last saw him alive on *Sept. 2*, 19*22*, and that death occurred, on the date stated above, at *12:30 P.* m.

The CAUSE OF DEATH* was as follows:

*Arteriosclerotic Reflexes*CONTRIBUTORY (Secondary) *Arteriosclerotic Reflexes* (duration) *2* yrs. mos. ds.18 Where was disease contracted (if not at place of death) *at place of death*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Urinary analysis*(Signed) *Dr. R. R. Krauter* M. D.19 (Address) *3902 Grosvenor St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenwood Cemetery *Sept 5 1922*

20 UNDERTAKER ADDRESS

H. E. Hughes 4241 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67291

CERTIFICATE OF DEATH.

D 67291E

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 E. Ostend St. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward L. Ernst(a) RESIDENCE. No. 135 E. Ostend St. ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 9 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 25 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	9	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)10 NAME OF FATHER Frank W. Ernst11 BIRTHPLACE OF FATHER (city or town) W. V. a.
(State or country)12 MAIDEN NAME OF MOTHER Helen E. Eckhardt13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)14 Informant Mr. Ernst
(Address) 135 E. Ostend St.15 SEP 4 - 1922 ROBERT A. KRAUSE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-4-2217 I HEREBY CERTIFY, That I attended deceased from 8-12-22 to 9-4-22that I last saw him alive on 8-28-22and that death occurred, on the date stated above, at 3:02 a.m.

The CAUSE OF DEATH* was as follows:

measles -

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Chronic Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Brown M. D.(Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery 9/5 1922

20 UNDERTAKER

J. Hew M. Bully 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH *Bay View Hospital*
 CITY OF BALTIMORE: (No. *Eastern Ave 15* ST., *15* WARD)
 2-FULL NAME *Sophia Humeau*
 (a) RESIDENCE NO. *1853 Bay View* ST., *15* WARD
 (Usual place of abode) (If non-resident give city or town and State)
 Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 67292

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1872*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *50*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer) *070*

(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)

10 NAME OF FATHER *James Johnson*

11 BIRTHPLACE OF FATHER (city or town) *Md.* (State or country)

12 MAIDEN NAME OF MOTHER *May Young*

13 BIRTHPLACE OF MOTHER (city or town) *Md.* (State or country)

14 Informant *Hospital Records* (Address)

15 Fi *SEP 4 - 1922* ROBERT R. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *9-3* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from *7-8*, 19 *22* to *9-3*, 19 *22*, that I last saw her alive on *9-3*, 19 *22* and that death occurred, on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast with metastases to right axilla.

(duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *Examination*

(Signed) *G. Richardson* M. D.

, 19 (Address) *Bay View Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JAMES H. DENNIS

1303 PRESTMAN ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

67293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67293

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5217 Decmore Ave. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 347 Decmore Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Earle E. Lane.

6 DATE OF BIRTH (month, day, and year) Aug 7/22.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
40 2 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Ollix Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Bruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) 3042 Decmore Ave. Earle E. Lane.

15 SEP 4 - 1922

ROBERT R. KRAUTER Registrar

Barth Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 4, 1922, to Sept 2, 1922.

that I last saw her alive on Sept 2, 1922.

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D. C. D.

9/3/22 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Randa View Md. Sept 5 1922

20 UNDERTAKER ADDRESS JAMES H. DENNIS

1303 PRESTMAN ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

D 67294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67294

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1709 Lancaster* ST., *2* WARD)

2-FULL NAME

Elizbeth Kryciak

(a) RESIDENCE NO.

*1709 Lancaster*ST., *2* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *2*mos. *9*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 25/22

7 AGE

Years

Months

Days

*2**9*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Stanislaus Kryciak

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Vronika Ostroma

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant

Stanislaus Kryciak

(Address)

1709 Lancaster St.

15

File

*SEP 4 - 1922**ROBERT R. KAUTER*

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 4, 1922

17

I HEREBY CERTIFY, That I attended deceased from *Aug. 28*, 19*22*, to *Sept 4*, 19*22*, that I last saw her alive on *Sept 3*, 19*22*, and that death occurred, on the date stated above, at *10 a.* m.

The CAUSE OF DEATH* was as follows:

Dysentery(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

John H. Ralberger M. D.

, 19

(Address) *1709 Olive Ave St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MORAL

St. Stanislaus

DATE OF BURIAL

SEP 5 - 1922

20 UNDERTAKER

W. F. Sadowski

ADDRESS

405 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

67295
PLACE OF DEATH

Bay View Hospital

78 D 67295
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1366 E. Bay View St. WARD)

2-FULL NAME

Henry Ridge

(a) RESIDENCE NO.

1135 Poplar Grove

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yr.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 1887

7 AGE

Years

Months

Ds.

If LESS than 1 day, hrs. or min.

35.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

off

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do

12 MAIDEN NAME OF MOTHER

Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do

14

Informant (Address)

Bay View Hospital 100 E. Bay View St. Md.

15

SEP 4 1922

ROBERT A. KRAMER, Registrar

Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 1, 1922

17

I HEREBY CERTIFY, that I attended deceased from

Apr. 17, 1919, to

Sept. 1, 1922

that I last saw him alive on

Sept. 1, 1922

and that death occurred, on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:

Status Epilepticus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Schiz. Phrenia

Reaction type (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. H. Adams, M. D.

Address Bay View Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Cemetery

20 UNDERTAKER

George J. Ruth

DATE OF BURIAL

Sept. 1922

ADDRESS

Sept. 6th

67296
D 67296

HEALTH DEPARTMENT—CITY OF BALTIMORE

67296

CERTIFICATE OF DEATH.

H4 D 67296

1-PLACE OF DEATH

Baltimore, Chester St.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, No.

Home for Incurables WARD

2-FULL NAME

Moses Hartz

(a) RESIDENCE. No.

1611 E. Pratt St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

68 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Rebecca Hartz

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Box merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

Boxes

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Tobias Hartz

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Rebecca Hartz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore

14

Informant
(Address)May Hartz
1611 E. Pratt St.

15

Filed

SEP 5 - 1922

G. H. Grese

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sep. 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 30, 1922, to Sep. 2, 1922,

that I last saw him alive on Sep 2, 1922,

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

M. D.

9/2, 1922 (Address)

210 N. 1st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR

DATE OF BURIAL

Baltimore Hebrew Sep 1922

2 UNDERTAKER

ADDRESS

J. Ahrens 1611 E. Pratt St.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

158140 HEALTH DEPARTMENT—CITY OF BALTIMORE. 67297

D 67297 67297, CERTIFICATE OF DEATH. 2 84 D 67297

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)
2-FULL NAME Mary McCarthy
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
(a) RESIDENCE NO. 330 W. 36th ST. New York, N.Y.
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred ? yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) Jan. 12 - 1897
7 AGE Years 25 Months 7 Days 23 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerical
(b) General nature of industry, business, or establishment in which employed (or employer) 009
(c) Name of employer

9 BIRTHPLACE (city or town) New York (State or country)

10 NAME OF FATHER Dennis McCarthy

11 BIRTHPLACE OF FATHER (city or town) N. Y. (State or country)

12 MAIDEN NAME OF MOTHER Mary Costello

13 BIRTHPLACE OF MOTHER (city or town) N. Y. (State or country)

14 JOHNS HOPKINS HOSPITAL
Informant (Address)

15 SEP 5 - 1922 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 31, 1922, to Sept 4, 1922, that I last saw him alive on Sept 4, 1922, and that death occurred, on the date stated above, at 11¹⁵ A. M.

The CAUSE OF DEATH* was as follows:
Brain tumor, glioma, left cerebral, invading lateral ventricle
(duration) 3 yrs. 3 mos. ? ds.

CONTRIBUTORY (Secondary) (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? N. Y.

Did an operation precede death? Yes Date of Sept. 2

Was there an autopsy? Yes

What test confirmed diagnosis? Operation - autopsy

(Signed) F. L. Reichert M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City DATE OF BURIAL Sept 4 1922

20 UNDERTAKER John C. Mitchell ADDRESS 1201 W. 14th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67298

90 D 67298

67298
D 67298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.

Baltimore

ST. ~~110~~ WARD

2-FULL NAME

Miss Ella Ryan

(a) RESIDENCE NO.

1206 Hayfield Ave.

ST. WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

1841

7 AGE

Years

Months

Days

If LESS than 1 day.....hrs. or.....min.

81

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Do not know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant

(Address)

Mr. R. A. Ryan

327 E 49th St New York

15

Filed

SEP 5 - 1922

M. Y.

G. H. Grease

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from 1-3, 1922, to 9-3, 1922,

that I last saw him alive on Sept 3, 1922,

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decomposition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. C. McQuinn, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

St. Patrick's Cem

9-5-1922

20 UNDERTAKER

Robert Brooks & Son

ADDRESS

Calhoun Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

0067299
91 D 67299

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 31. S. Calhoun ST., 19 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds.

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? 40 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow
5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Stritz
6 DATE OF BIRTH (month, day, and year) July 2, 1846
7 AGE Years 76 Months 7 Days 1 If LESS than 1 day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

SEP 5-1922

G. H. Grace Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3, 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1922 to Sept 3, 1922.
That I last saw her alive on Sept 3, 1922, and that death occurred, on the date stated above, at 8:15 A. M.
The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? 26

What test confirmed diagnosis? Clinical

(Signed) E. V. C. M. D.

9/4, 1922 (Address) 24 W. Fulton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Robert Brooks & Son

DATE OF BURIAL

9-5-1922

ADDRESS

Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

67300
D 67300

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2724 N Charles ST. 12 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or /9 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

SEP 5 - 1922

Filed

19

G. H. Green Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1922, to Sept 4, 1922, that I last saw her alive on Sept 4, 1922, and that death occurred, on the date stated above, at 3.40 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ☒ Date of

Was there an autopsy? ☒

What test confirmed diagnosis?

(Signed) Dr. J. F. Kelly M. D.

(Address) 2724 N Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

London Park Cem

Robert Brooks & Sons

9-5-1922

Baltimore Hollins St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

67301
D 67301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67301
D 67301

1-PLACE OF DEATH

City of BALTIMORE: (No. 1042 Granby St., 3 Ward)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1038 Granby St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male
4-COLOR OR RACE. White
5-Single, Married, Widowed, or Divorced. (Write the word.) Unknown

6-DATE OF BIRTH. Unknown
(Month) (Day) (Year)

7-AGE. About 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Unknown
(b) General nature of industry, business, or establishment in which employed (or employer). 087

9-BIRTHPLACE, (State or Country). Pittsburgh Pa

10-NAME OF FATHER. Wm Kohlwe

11-BIRTHPLACE OF FATHER, (State or Country). Pittsburgh Pa

12-MAIDEN NAME OF MOTHER. Elizabeth Parsick

13-BIRTHPLACE OF MOTHER, (State or Country). Pittsburgh Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. C. Co. Balto. Md

(Address) Lombard St. Falls Co.

15-

Filed SEP 5 - 1922 G. H. Grace Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 2nd 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. D. Worton M. D.
(Coroner)
(Address) Curtis Bay, Balto

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence. two mks.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Pittsburg Pa Sept 4th 1922

20-UNDERTAKER. ADDRESS

Geo M. Smith Inc 811 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67302

67302

HEALTH DEPARTMENT—CITY OF BALTIMORE

67302

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital* ST. *7* WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs. — mos. — ds.

How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

May 31st 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

3 (3) *4* (4)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Clerk

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

John A. Schleicher

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Richmond Va

12 MAIDEN NAME OF MOTHER

Anna Wagner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Richmond Va

14

Informant

(Address)

Miss Lou Schleicher

2428 E. Monument St

15

SEP 5 - 1922

G. H. Green

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

7-19 1922 to *7-4 1922*

that I last saw him alive on

7-4 1922

and that death occurred, on the date stated above, at *12 30 P* m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(duration)

6 weeks yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Cardiac failure

(duration)

3 yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical + Laboratory

(Signed)

W. C. Caldwell

M. D.

, 19

(Address)

St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Richmond Va

Sept 5 1922

F. B. Mappert 2236

St. Agnes

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67303

1-PLACE OF DEATH

City of BALTIMORE: (No. 1230 Jefferson St. 5 Ward)

Registered No. C. 67303

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1230 Jefferson St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE Black 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, July 9 1912 (Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Belts

10-NAME OF FATHER, Edwin Jackson

11-BIRTHPLACE OF FATHER, (State or Country), Belts

12-MAIDEN NAME OF MOTHER, Martha Chapman

13-BIRTHPLACE OF MOTHER, (State or Country), Belts

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Jackson

(Address) 1230 Jefferson St.

15, SEP 5 - 1922 G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 3 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said inquest, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brachy - Pneumonia

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. P. (Coroner)

1922 Address

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Laurel Cem. Sept 5 1922

20-UNDERTAKER, ADDRESS

Mrs. J. G. Locks 1302 Jefferson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bka.

D 67304 HEALTH DEPARTMENT—CITY OF BALTIMORE **100-1006 D 67304**
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1157 Columbia Ave ST. 21 WARD)

2-FULL NAME

Pearl E. Holsey

(a) RESIDENCE No. 1157 Columbia Ave ST. 21 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
9 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) md

10 NAME OF FATHER Andrew F. Holsey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) md

12 MAIDEN NAME OF MOTHER Marion H. Linn

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) md

14 Informant Andrew F. Holsey
(Address) 1157 Columbia Ave

15 SEP 5 - 1922 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922 to Sept 3, 1922 that I last saw her alive on Sept 3, 1922 and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Reed M. Kieffer M. D.
Sept 22 19 (Address) 2320 Wash Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL
Not Olivet

DATE OF BURIAL

Sept 6 1922

20 UNDERTAKER

George J. Smith

ADDRESS

600 W. Fayette St.

67305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 67305

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1075 W Lexington* ST. *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Caetharine T Blair

(a) RESIDENCE. No.

1075 W Lexington ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

44 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Landowner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

James Blair

11 BIRTHPLACE OF FATHER (city or town)

Va.

(State or country)

12 MAIDEN NAME OF MOTHER

Mary Smith

13 BIRTHPLACE OF MOTHER (city or town)

Va.

(State or country)

14

Informant (Address)

James Williams
1075 W Lexington St

15

SEP 5 - 1922

C. H. Goss

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 3 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

July 10, 19*22*, to *Sept 2*, 19*22*.that I last saw him alive on *Sept 2*, 19*22*.and that death occurred, on the date stated above, at *2:30 P.* m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *No*

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Laurel Hill**Sept 5* 19*22*

20 UNDERTAKER

ADDRESS *114 W.**Brown & Tiedland* *Schneider*

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67306 HEALTH DEPARTMENT—CITY OF BALTIMORE 001 D 67306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1757 Mulligan St., 6 Ward)

Registered No. C.....

2-FULL NAME.

(Residence in Baltimore: No. 1757 Mulligan St.; yrs. 45 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Black

5-Married,
or Divorced.
(Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year)

7-AGE,

68 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 5 - 1922

G. H. Grese

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 2, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy -
Left sided paralysis arm & leg
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. S. Waller M. D.
(Coroner)
1922 (Address) 508 E. North

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Asbury Cemetery Sep 5th, 1922

20-UNDERTAKER,

ADDRESS

Milton Davis 315 W. Eden St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIAN'S SIGNATURE AND STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

D 67307 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 W Barre ST., 22 WARD)

2-FULL NAME

Agnes A. Varina

(a) RESIDENCE NO.

624 W Barre ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 6/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

5 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

John W Varina

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Laretta Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Mrs Walter Varina 624 W Barre St.

15

Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 2nd, 1922, to Sept 4th, 1922.

that I last saw her alive on Sept 3rd, 1922.

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

CONTRIBUTORY (Secondary)

(duration)

ys.

mos.

ds.

(duration)

ys.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Western Cemetery

Sept 5 1922

20 UNDERTAKER

ADDRESS

F.A. Krause & Son

203 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 67308

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Municipal Pk Hosp* WARD)

2. FULL NAME

(a) RESIDENCE NO. *548 Oxford* ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *wh.* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balt Md.* (State or country)

10 NAME OF FATHER *Julius Wildt*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *Marie Kress*

13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14 Informant *Hosp. Records.* (Address)

15 *G. H. Gress* *G. H. Gress* Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 3 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Aug 11*, 19*22*, to *Sept 3*, 19*22*, that I last saw *her* alive on *Sept 3*, 19*22*, and that death occurred, on the date stated above, at *5:50 P. m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Ec.

(duration) yrs. *7* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Ray & Spentum*

(Signed) *Frederic L. Dodge*, M. D.

, 19 (Address) *Municipal Pk. Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

London Park Cemetery

Sept 5 1922

20 UNDERTAKER

ADDRESS

Geo Leinbach & Co

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67309 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 67309

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 Orleans ST. 6 WARD)

2-FULL NAME

Ida Kaplan

(a) RESIDENCE NO.

2408 Orleans ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 27 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Isreal Kaplan 1886

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

36

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Harry Creamer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Katie Zallouf

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E. 34th St. N. B.

SEP 5 - 1922

Filed

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1921, to Sept 4, 1922,

that I last saw her alive on Sept 3, 1922,

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Baltimore

Did an operation precede death? Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Positive Sputum

(Signed)

Jack Lewis

M. D.

9/4, 1922 (Address)

2235 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOHAR Nelson Rosedale

9/5 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. 34th St. N. B.

D 67310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 67310

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 341 P. Vincent ST.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 371 P. Vincent St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
 6-DATE OF BIRTH May 8, 1922
 (Month) (Day) (Year)
 7-AGE 3 25 If LESS than 1 day, hrs. or min.
 (yrs.) (mos.) (ds.)
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work Doc
 (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country), Baltimore

10-NAME OF FATHER Winfield Turpin
 11-BIRTHPLACE OF FATHER (State or Country), Denton, Md.
 12-MAIDEN NAME OF MOTHER Margaret Hall
 13-BIRTHPLACE OF MOTHER (State or Country), Balto., City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Turpin
(Address) 341 P. Vincent St

15-

Filed Sept 5-1922 Robt. T. 191 Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 3rd, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 2nd 1922, to Sept. 3rd 1922, that I saw him alive on Sept. 2nd 1922, and that death occurred, on the date stated above, at 1410 m.
 The CAUSE OF DEATH* was as follows:
acute
laryngeal
infection
 (Duration) yrs. mos. ds.
 CONTRIBUTORY (Secondary)
 (Duration) yrs. mos. ds.
 (Signed) R. T. Muesel M. D.
Sept. 3rd 1922 (Address) 130 P. Gilman St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Auburn Cem. DATE OF BURIAL, Sept 5th, 192220-UNDERTAKER A. Jones ADDRESS 111 S. Gilman St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

67311 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67311

PLACE OF DEATH

CITY OF BALTIMORE (No. 1411 Cairo St.

2-FULL NAME Harriett Mears

(Residence in Baltimore: No. 1411 Cairo St.

REGISTERED NO. C

ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 0 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female 4-COLOR OR RACE, colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed

6-DATE OF BIRTH, about 1849 (Month) (Day) (Year)

7-AGE, 73 yrs. 0 mos. 0 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laundry (b) General nature of industry, business, or establishment in which employed (or employer), 841

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Mears (Address) 1411 Cairo St.

15- Robert P. Harrison, Registrar. 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 3, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease (Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) no history (Duration) 1 yrs. 0 mos. 0 ds.

(Signed) J. T. Harrison, M. D. (Coroner.) Sept. 4, 1922 Address 802 E. Edwards St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 0 mos. 0 ds. In the State yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Zion Ch. DATE OF BURIAL, Sept 5, 1922

20-UNDERTAKER, Daniel E. Egan ADDRESS 916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67313

CERTIFICATE OF DEATH.

179 D 67313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Ensor St.

ST., 9 WARD)

2-FULL NAME

Edna. L. Seebach

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1407 Ensor St.

ST., WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

23 yrs.

mos.

26 ds.

How long in U. S., if of foreign birth?

Life

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Louis. J. Seebach

6 DATE OF BIRTH (month, day, and year) Aug. 6-1899

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

23

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Powers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

Edna L. Seebach 1407 Ensor St.

SEP 5 - 1922

G. H. Grace

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. -4-1922

17

I HEREBY CERTIFY, That I attended deceased from

July 15, 1921, to Sept 4, 1922, that I last saw her alive on Sept 4, 1922, and that death occurred, on the date stated above, at 9:40 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. J. Kimzey M. D.

9, 1922 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery

Sept 7 1922

20 UNDERTAKER

ADDRESS

Henry Horck Sow

1301 E. Eager

D 67314 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 N. Calvert ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 631 N. Calvert ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 23 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Philadelphia

10 NAME OF FATHER

Michael J. Conroy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Michael Conroy 631 N. Calvert St.

SEP 5 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

August 23, 1922, to September 4, 1922, that I last saw him alive on Sept 2, 1922

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

at place of death

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical examination

(Signed)

P. E. Kelly M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery

Sept 5 1922

20 UNDERTAKER

Wm. Cook

502 E. North Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of UPA-TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 67315 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67315

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1678 Norwood Ave ST. WARD)

2. FULL NAME Mary Francis Harris

(a) RESIDENCE NO. 1678 Norwood Ave ST. WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Harris

6 DATE OF BIRTH (month, day, and year) Mar. 27, 1877

7 AGE Years 45 Months 5 Days 6 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

10 NAME OF FATHER Thos. Raymond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Francis Stecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Wm Harris (Address) 1628 Norwood Ave

SEP 5 - 1922

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1922, to Sept 3, 1922

that I last saw him alive on Sept 3, 1922

and that death occurred, on the date stated above, at 6:20 a. m.

The CAUSE OF DEATH* was as follows: over

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Gray, M. D.

(Address) 627 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm Cook, 502 E. North Ave

D 67316

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2426 E. Federal ST., 8 WARD)

2-FULL NAME

(a) RESIDENCE No. 2426 E. Federal ST., 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

William Crudden

6 DATE OF BIRTH (month, day, and year)

May 17 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76 3 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home-work

(b) General nature of industry, business, or establishment in which employed (or employer)

DB7

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Maryland

10 NAME OF FATHER

Eli Chamer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Perryman, Maryland

12 MAIDEN NAME OF MOTHER

Mary Foreman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Perryman, Maryland

14

Informant (Address)

William F. Soyars 2426 E. Federal St.

SEP 5 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

May 5, 1922, to Sept 4, 1922.

that I last saw him alive on Sept 3, 1922.

and that death occurred, on the date stated above, at 9.24 m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration)

yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. 6 mos. ds.

18 Where was disease contracted

if not at place of death?

At home

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

None

(Signed)

Richard C. Conklin, M. D.

Sept 4, 1922

Address 1514 E. Kulta St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Lorraine Cemetery, Sept 6 1922

10 FUNERAL

ADDRESS

William Oak 502 E. Nuth

D 67317 HEALTH DEPARTMENT-CITY OF BALTIMORE D 67317

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1735 Guilford

ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 1735 Guilford

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds.

ST. WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE white. 5 Single, Married, Widowed, or Divorced (write the word) widowed

5a If married, widowed, or divorced

(HUSBAND of (or) WIFE of

James Robert Kirby

6 DATE OF BIRTH (month, day, and year) July 18, 1867

7 AGE Years 65 Months 1 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charleston (State or country) South Carolina

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Lake City (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Kingstree (State or country) S. Carolina

14

Informant (Address)

15

Filed 5-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from August 31, 1922, to Sept. 3, 1922

that I last saw her alive on Sept 3, 1922

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Paraplegia)

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. A. C. Turner, M. D.

, 19 (Address) 6 E Preston, Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery Sept 5, 1922

20 UNDERTAKER

Walt & Turner Inc 11 Broadway

10 67318

HEALTH DEPARTMENT—CITY OF BALTIMORE D. 67318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Abraham Molack

(a) RESIDENCE NO.

213 S. Bethel St. City

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Rachel Molack (wife)6 DATE OF BIRTH (month, day, and year) Aug 20 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63??

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Calb Molack

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Amanda Cornish

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

JOHNS HOPKINS HOSPITALRecords

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cambridge Md

DATE OF BURIAL

Sept 6 1922

20 UNDERTAKER

John W Henderson

ADDRESS

Emmourt

SEP 5 - 1922

PHYSICIAN'S NAME and state
 EXACTLY. Exact statement of OCCASION
 AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCASION
 CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67319 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67319

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Eastern Ave. 26

WARD)

2. FULL NAME

Ruelma King
at Alms House 9 yrs.

(a) RESIDENCE NO.

1110 Hill Allen

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

68 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

D70

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

George R. King

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Eliz. Wayne

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Hospital Record

15

SEP 3 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9 - 2 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

9 - 12 - 1922 to 9 - 2 - 1922

that I last saw her alive on 9 - 2 - 1922

and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of head of pancreas

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis?

Examination

(Signed) J. Richardson, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Carmel Cemetery

DATE OF BURIAL

9/5 1922

20 UNDERTAKER

Chas. J. Evans & Son 1110 N. Calver Ave

PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of UPA-TION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D. 67320

D. 67320

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 S Durham ST. V WARD)

2-FULL NAME

(a) RESIDENCE NO. 429 S Durham ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, that I attended deceased from Sept 1, 1922 to Sept 4, 1922

that I last saw him alive on Sept 3, 1922

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? W Date of

Was there an autopsy? W

What test confirmed diagnosis?

(Signed) William H. Jones, M. D.

(Address) 824 E. ... State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

SEP 5 - 1922

Registrar

John M. Weber 1803 Bank

Every item of information should be stated EXACTLY. PHYSICIAN should state OCCUPATION of DECEASED. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67321

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67321

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Broadway ST., 2 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Emily Lederer

6 DATE OF BIRTH (month, day, and year)

March 16, 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

5

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer)

019

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

John Lederer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Thunigunda Steinmetz

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

John Lederer 105 S. Broadway

15

SEP 5 - 1922

19

H. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

August 29, 1922, to Sept - 3 - 1922

that I last saw him alive on Sept 3, 1922

and that death occurred, on the date stated above, at 11:10 P. M.

The CAUSE OF DEATH* was as follows:

Enteritis Acute

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) M. P. K. M. D.

19

(Address)

125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Greenmount Cemetery H. Sander Sons

DATE OF BURIAL

ADDRESS

Sept 6 1922 1710 Read St.

D 67322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 636 S Linwood Ave. ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henry Trochlich

(a) RESIDENCE NO.

636 S Linwood Ave. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary E. Trochlich

6 DATE OF BIRTH (month, day, and year)

Jan 16 1863

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

59

7

17

8 OCCUPATION OF DECEASED

none for past

(a) Trade, profession or particular kind of work

3 or 4 years. formerly

(b) General nature of industry, business, or establishment in which employed (or employer)

in insurance co.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

not known

Germany

10 NAME OF FATHER

John Trochlich

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

not known

Germany

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)Mary E. Trochlich
636 S Linwood Ave.

SEP 5 - 1922

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 30, 1922, to Sept 3, 1922,

that I last saw him alive on Aug 30, 1922,

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(apoplexy) and attack.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) severe yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) J. W. Miller, M. D.

9/4, 1922 (Address) 1014 S. Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel Cemetery

Sept 5 1922

20 UNDERTAKER

ADDRESS

A. Vander & Sons 1740 Fleet St.

91-00

1-PLACE OF DEATH

REGISTERED NO......
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 0331 E 21 ST., WARD.

(Usual place of abode)				(If nonresident give city or town and State)			
Length of residence in city or town where death occurred	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 19 22

17 I HEREBY CERTIFY, That I attended deceased from
Sept 2, 1922 to Sept 4, 1922
that I last saw her alive on Sept 3, 1922
and that death occurred, on the date stated above, at 12:55 p. m.

The CAUSE OF DEATH* was as follows:

old age
arterio sclerosis

..... (duration) .., .. yrs. mos. ds

CONTRIBUTORY (Secondary) Marathon

.....(duration) yrs. mos. d3.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? _____
(Signed) Rogerald S. Tonny D.
_____, 19 ____ (Address) 4149 North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
19	

20 UNDERTAKER ADDRESS

Filed 1922 19 *H. A. M.* Registrar

D 67324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67324

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins St. Hops* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *York, Pa* St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-Single, Married, Widowed, or Divorced, (Write the word.)
-----------------------	----------------------------------	--

6-DATE OF BIRTH,, 1..... (Month) (Day) (Year)

7-AGE, <i>55</i> yrs., mos., ds.	If LESS than 1 day, hrs. or min.?
-------------------------------------	--

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).	<i>Hotel off Super</i>
--	----------------------------

9-BIRTHPLACE, (State or Country),	<i>Pa.</i>
--------------------------------------	------------

PARENTS	10-NAME OF FATHER, <i>Peter Wolf</i>
	11-BIRTHPLACE OF FATHER, (State or Country), <i>Pa</i>
	12-MAIDEN NAME OF MOTHER, <i>Unknown</i>
	13-BIRTHPLACE OF MOTHER, (State or Country), <i>Unknown</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Wolf*(Address) *York, Pa.*

SEP 5 - 1922

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, <i>Sept 4</i> (Month) (Day) (Year)
--

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Portable steel following surgical operation for supposed brain tumor

(Duration) yrs. mos. ds.

CONTRIBUTORY *Adenoma prostate* (Secondary) *(over)**manic - psychotic* (Duration) yrs. mos. ds.(Signed) *J. S. Haller* M. D. (Coroner.)9-5 1922 (Address) *508 E. North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

York Pa *Sept 6, 1922*

20-UNDERTAKER, ADDRESS

Joseph Adams 221 Bway

D 67325
15796

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emmet McDuttyre

(a) RESIDENCE NO.

1213 Luzerne

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2 mos. 18 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 17 - 1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.—218

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Md.

10 NAME OF FATHER

Edward McDuttyre

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER

Minnie Allender

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Co. Md.

14

Informant
(Address)JOHNS HOPKINS HOSPITAL

SEP 5 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

, 19

to Sept 4, 1922that I last saw him alive on Sept 4, 1922and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Congenital malformation
of bile ductsCONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

Horton Casparis, M. D.

, 19

(Address)

Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Johns Cemetery Long Green

20 UNDERTAKER

Lilly & Zieher

DATE OF BURIAL

Sept. 6 1922

ADDRESS

403 S. Wolfe St.

D 67326 HEALTH DEPARTMENT—CITY OF BALTIMORE 67326

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 E. Heath St. St. 22 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Julia R. Smith.

(Residence in Baltimore: No. 17 E. Heath St. St.; yrs. 41 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Married (Write the word.)

6-DATE OF BIRTH, September 12th, 1880. (Month) (Day) (Year)

7-AGE, 41 yrs. 11 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer), 037

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, George Gold.

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Cornelia Jackson.

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ora D. Smith. (husband)

(Address) 17 E. Heath St.

15- Filed SEP 5 1922 J. E. Kohn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 2nd, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) Otto M. P. (Coroner.)

Feb. 5th 1922 Address 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL.

Western View Sept 5, 1922

20-UNDERTAKER ADDRESS

Wm. E. Evans 1428 N. ...

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67327

D 67327

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 173/ William ST. 24 WARD)

2. FULL NAME

Dora G. Don Berger

(a) RESIDENCE NO.

173/ William ST. 24 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, divorced, or separated, name of husband, wife, or child

(or) WIFE of

Richard Don Berger

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

SEP 5 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

my 1921, to Sept 3, 1922

that I last saw him alive on Sept 2, 1922

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Campbell M. D.

(Address) 1644 Hancock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cem 9/6/1922

20 UNDERTAKER

ADDRESS

Jno J. Faber 1318 Light St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 67328

HEALTH DEPARTMENT—CITY OF BALTIMORE

67328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs. Sarah Goldstein

(a) RESIDENCE. NO.

2115 E. Lombard

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

21 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

27 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Benjamin Goldstein

6 DATE OF BIRTH (month, day, and year)

1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Abraham Goldstein

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Eva -

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

Benjamin Goldstein
2115 E. Lombard St.

SEP 5 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Sept 5, 1922, that I last saw him alive on Sept 5, 1922, and that death occurred, on the date stated above, at 1:10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Malignant

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Aortic valve disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Ellaville, M. D.

7/5, 1922 address Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Hospital

9-5-22

20 UNDERTAKER

ADDRESS

Fact Lums, 1439 E. Balto

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health ASSO.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Suspected carcinoma
of stomach*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67329

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *25* WARD)

2. FULL NAME

Mr Charles Bauer

(a) RESIDENCE NO.

3rd Ave Brooklyn Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. *14* mos. *18* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mr Mammie Bauer

6 DATE OF BIRTH (month, day, and year)

May 20 1887

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

35

3

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Ship Carpenter

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Brooks Ship yard

(c) Name of employer

Brooks Ship yard

9 BIRTHPLACE (city or town)
(State or country)

Balto

10 NAME OF FATHER

Joseph Bauer

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Balto

12 MAIDEN NAME OF MOTHER

Mary E. Ott

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Balto

14

Informant
(Address)

*Mammie Bauer (wife)
3rd Ave - Brooklyn Ph.*

SEP 5 - 1922

H.A.W.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 3 1922*

17

I HEREBY CERTIFY, That I attended deceased from
July 17, 19*22*, to *Sept 3*, 19*22*.
that I last saw him alive on *Sept 3*, 19*22*,
and that death occurred, on the date stated above, at *11:50 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) ? yrs. mos. ds.
CONTRIBUTORY *Carcinomatous Cachexia*
(Secondary) (duration) ? yrs. 2 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? *Yes* Date of *7/26/22*

Was there an autopsy? *No*

What test confirmed diagnosis? *Path Diag*

(Signed)

Samuel J. Peacock M.D.

1919 & 24 Address

Mary Ott

*State the Disease Causing Death or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Holy Cross A.C.C.

DATE OF BURIAL

9-6 1922

20 UNDERTAKER

Er B Harle

ADDRESS

115 E West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67330

CERTIFICATE OF DEATH.

REGISTERED NO. C

D 67330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph Hosp.* ST. *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Joseph Cummings*

(Residence in Baltimore: No. _____ St. _____ yre. _____ mos. _____ da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male*4-COLOR OR RACE, *white*

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, _____, *1* _____

(Month)

(Day)

(Year)

7-AGE, *58*

yrs. _____ mos. _____ da.

If LESS than 1 day, _____ hrs. or _____ min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____ *086*

9-BIRTHPLACE, (State or Country), _____

PARENTS.

10-NAME OF FATHER, _____

11-BIRTHPLACE OF FATHER (State or Country), _____

12-MAIDEN NAME OF MOTHER _____

13-BIRTHPLACE OF MOTHER (State or Country), _____

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15-

Robert P. Harrison

UNIVERSITY OF MARYLAND

1922

Burial Permit Clerk: Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *August 31, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *August 9, 1922*, to *Aug. 31, 1922*,that I saw him alive on *Aug. 31, 1922*,and that death occurred, on the date stated above, at *4P* m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(Duration) _____ yrs. _____ mos. _____ da.

CONTRIBUTORY (Secondary) *Chronic nephritis*

(Duration) _____ yrs. _____ mos. _____ da.

(Signed) *John A. Schurck* M. D.*Aug. 31, 1922* (Address) *St. Joseph Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death _____ yrs. _____ mos. _____ da. In the State _____ yrs. _____ mos. _____ da.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL, _____

DATE OF BURIAL, _____, 191...

20-UNDERTAKER _____

ADDRESS _____

SEP 5 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67331

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3530 Benson St. 13 WARD)

2-FULL NAME George A. Chrest

(a) RESIDENCE NO. 3530 Benson St. 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Lizzie M. Chrest (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 6-1862

7 AGE Years 60 Months 7 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Street paver

(b) General nature of industry, business, or establishment in which employed (or employer) U. P. & E. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Westminster Maryland (State or country)

10 NAME OF FATHER Geo. A. Chrest

11 BIRTHPLACE OF FATHER (city or town) Westminster Maryland (State or country)

12 MAIDEN NAME OF MOTHER Jane Fowler

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Mrs. Lizzie M. Chrest (Address) 3530 Benson St.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 30th, 1922, to Sept 3rd, 1922, that I last saw him alive on Sept 3rd, 1922, and that death occurred, on the date stated above, at 2¹⁰ m.

The CAUSE OF DEATH* was as follows: acute cardiac dilation

(duration) yrs. mos. ds.

CONTRIBUTORY Hy & blood pressure Chronic (Secondary) Probable arteriosclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? xps

(Signed) B. G. Sullivan, M. D.

9/4, 1922 (Address) 1527 Union St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-BURIAL

20 UNDERTAKER Horace H. Bungee 363 Falls Rd.

DATE OF BURIAL Sept. 6 1922

5-1922

Burial Permit Clerk.

D 67332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67332

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 S. Exeter ST., 3 WARD)

2. FULL NAME

Salvatore Pules

(a) RESIDENCE NO.

220 S. Exeter

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 16, 1901

7 AGE

20 Years9 Months20 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy

10 NAME OF FATHER

Ignazio Pules

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Italy

12 MAIDEN NAME OF MOTHER

Vincenza Cicola

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Italy

14

Informant

Vincenza Cicola

(Address)

220 S. Exeter

15

Robert P. Harrison,

19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

December 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 16, 1922, to September 5, 1922,that I last saw him alive on September 4, 1922,and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

Exhaustion(duration) yrs. 2 mos. — ds.

18 Where was disease contracted

if not at place of death? don't knowDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? By Examination(Signed) Frederick B. Roemer, M. D., 19 (Address) 112 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Holy Redeemer Ch

DATE OF BURIAL

9/16 1922

20 UNDERTAKER

George J. Ruth

ADDRESS

1735 Hayford

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

P5-1922

Physicians should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Rks.

D 67333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67333

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2770 Alameda Ave. ST., 9 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Ruff

(a) RESIDENCE No. 2770 Alameda Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ruff

6 DATE OF BIRTH (month, day, and year) Dec 27, 1863

7 AGE 54 Years 8 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Frank Ruff

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Mary Helenberger

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mary Ruff (Address) 2770 Alameda Ave

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 19 22, to Sept 4, 19 22, that I last saw him alive on Sept 4, 19 22, and that death occurred, on the date stated above, at 11 P. m. The CAUSE OF DEATH* was as follows:

Diabetic Angeritis

CONTRIBUTORY (Secondary) Diabetic Coma (duration) 4 yrs. 4 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? J. H. H. M. D. (Signed) J. H. H. M. D. (Address) 1228 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Cross A.A.C.

20 UNDERTAKER George J. Ruth

DATE OF BURIAL

9/8 1922

ADDRESS

1735 Harford Ave

matron should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. (Marie Legg)

D 67334 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67334

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1052 N Guy ST., 7 WARD)

2-FULL NAME Mered 29 Legg

(a) RESIDENCE NO. 1052 N Guy ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George W Legg

6 DATE OF BIRTH (month, day, and year) May 11, 1864

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

58 4 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk England

10 NAME OF FATHER Alfred Legg

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) W Hopps 17 Rosemont Ave

15 Robert P. Harrison, Registrar

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

16 DATE OF DEATH (month, day, and year) Sept 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1922, to Sept 2, 1922, that I last saw him alive on Sept 2, 1922, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows: Asthma.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1242 N Guy St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geo F Taylor, M. D.

9-24-22 (Address) 1254 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Oaklawn Cemetery 9/22/22

20 UNDERTAKER ADDRESS

George J Ruth 5155 Harford Ave

D 67335

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1425 W Lombard St. 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Emma M. Pirsch

(Residence in Baltimore: No. 1475 W Lombard St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.) *Widowed*

6-DATE OF BIRTH, March 17, 1873 (Month) (Day) (Year)

7-AGE, 79 yrs. 8 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer), *Retired*9-BIRTHPLACE, (State or Country), *Balt City*10-NAME OF FATHER, *Conrad Garman*11-BIRTHPLACE OF FATHER, (State or Country), *Balt City*12-MAIDEN NAME OF MOTHER, *Lidia Walz*13-BIRTHPLACE OF MOTHER, (State or Country), *Balt City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *C. Ernst Pirsch*(Address), *#26 Summer St. Rd.*

15- Robert P. Harrison, Registrar.

5-1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy
(2nd attack - 7 mos)
sudden
(Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *arteriosclerosis*(Signed) *James M. Peniston* M. D.(Address) *1000 E. Charles St.*

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park*DATE OF BURIAL, *Sept 7, 1922*20-UNDERTAKER, *George J. Smith*ADDRESS *Fayette St.*

D 67336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 117

D 67336

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Woman's Hospital* ST., *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Bettie Rice Magruder*(a) RESIDENCE NO. *Glendale, Md.* ST., *Glendale Md.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *16* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

(or) WIFE of

*Caleb C. Magruder*6 DATE OF BIRTH (month, day, and year) *Aug. 19, 1842*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
80 *0* *16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Culpeper Virginia

10 NAME OF FATHER

Dr. Richard Thom. Halle

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Culpeper Virginia

12 MAIDEN NAME OF MOTHER

Ellen Anne Hove

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Fauguier Virginia

PARENTS

14 Informant

C. C. Magruder Jr.

(Address)

Upper Marlboro, Md.

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 4* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Aug. 19*, 19 *22*, to *Sept. 4*, 19 *22*, that I last saw him alive on *Sept. 4*, 19 *22*, and that death occurred, on the date stated above, at *11:10 P* m.

The CAUSE OF DEATH* was as follows:

acute dilatation of the heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Myocarditis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

*born*Did an operation precede death? *Yes* Date of *Aug. 19, 1922*Was there an autopsy? *no*What test confirmed diagnosis? *Physical Exam.*(Signed) *G. F. Goff* M. D., 19 (Address) *Woman's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Bell/Princed George *Sept 6, 1922*

20 UNDERTAKER

ADDRESS

Shewart & Mowen Co. 108 N. North Ave

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

5-1922

174
REGISTER

1-PLACE OF DEATH

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

(a) RESIDENCE. NO. 34 E. Barney St. ST. _____ WARD. _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred 67 yrs 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs _____ mos. _____ ds. _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4. 1922

17 I HEREBY CERTIFY, That I attended deceased from
Aug . 5 1922 to Sept 4 1922.

that I last saw her alive on Sept 4, 1922
and that death occurred, on the date stated above, at 12.30 Pm.

(b) General nature of industry, business, or establishment in which employed (or employer)

The CAUSE OF DEATH* was as follows:

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?.....No

What test confirmed diagnosis: Clinical
(Signed) J. F. Van Buren, M. D.

9/16/1947 (Address) 1 E. Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL

Loudon Park Cem.

9. 7 1921

20 UNDERTAKER

ADDRESS

I. Few Mr. Galt

190 E. 7th

D 67338

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 67338

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Brentwood Ave. ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

S. Frances Porter

(a) RESIDENCE NO.

1121 Brentwood Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Robert Porter

6 DATE OF BIRTH (month, day, and year) Apr. 1st 1840

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

82

5

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Frederick

Md.

10 NAME OF FATHER Solomon Albaugh

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md.

12 MAIDEN NAME OF MOTHER Miss Kauntner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

U. S.

14

Informant Mrs. J. Edward Wood
(Address) 1121 Brentwood Ave.

15

Filed SEP 6 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4th 19 22

17

I HEREBY CERTIFY, That I attended deceased from

August, 1920, to Sept 4, 1922.

that I last saw him alive on Sept 4, 1922.

and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Disease

(duration) 2 yrs. + mos. ds.

CONTRIBUTORY Hypertension, Congestive Heart Failure
(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Hubert C. Knapp, M. D.

9/5, 1922 (Address) 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Landon Park Cemetery

Sept 6th 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67339

CERTIFICATE OF DEATH.

113 D 67339

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 854 W. Island ST. 21 WARD)

2-FULL NAME

Holland O Saunders

(a) RESIDENCE. No.

854 W Island

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 5 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Jernigan Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Edna Crossley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Jernigan Saunders 854 W Island

15 Filed SEP 6 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5/22

17

I HEREBY CERTIFY, That I attended deceased from 8/10/22, 1922, to 9/5/22, 1922, that I last saw him alive on 9/5/22, 1922, and that death occurred, on the date stated above, at 12:35 p.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. J. Smiley, M. D.

9/5/22 (Address) 908 S Sharps

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Ct

Sept. 7 1922

20 UNDERTAKER

ADDRESS

J. L. Brown & Son

108 W. Mondy

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67340

CERTIFICATE OF DEATH.

89 D 67340

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 N. Carey ST., 18 WARD)

2-FULL NAME

John J. Thornton

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

117 N. Carey St.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

61 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Sallie E. Thornton

6 DATE OF BIRTH (month, day, and year)

Apr 16. 1861

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

61

4

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Com. merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

Aaron Thornton

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Flora Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore Md.

14

Informant
(Address)Sallie E. Thornton
117 N. Carey St.

15

Filed

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 19 22

17

I HEREBY CERTIFY, That I attended deceased from

9/5/22, 1922, to 9/5/22, 1922

that I last saw him alive on 9/5/22, 1922

and that death occurred, on the date stated above, at 8:00 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY
(Secondary)

Arteriosclerosis

(duration) 10 yrs. 0 mos. 0 ds.

18 Where was disease contracted

if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symp. & exam

(Signed) R. A. Warner, M. D.

9/5/22 (Address) 700 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Dours. A. A. Co. Md. Sept 7 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 1201 N. Fayette

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 67341

CERTIFICATE OF DEATH

67341

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 156. Calver

ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Pollard

(Residence in Baltimore: No. 156. Calver

St. 50 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Colored 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word)

6-DATE OF BIRTH ———, 1856 (Month) (Day) (Year)

7-AGE 66 yrs. — mos. — ds. or — min. ? If LESS than 1 day, — hrs.

8-OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Richmond, Virginia.

10-NAME OF FATHER unknown.

11-BIRTHPLACE OF FATHER (State or country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Collins

(Address) 156 Calver St.

15

SEP 6 - 1922

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REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH September 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 12, 1922, to September 4, 1922.

that I saw her alive on September 4, 1922.

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

(Duration) — yrs. — mos. — ds.

Contributory (SECONDARY) Exhaustion

(Duration) — yrs. — mos. — ds.

(Signed) Frederick S. Hooper M. D.

September 5, 1922. (Address) 112 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

Arboretum Cemetery

DATE OF BURIAL

Sept 7, 1922

20-UNDERTAKER

Edward Bryson

ADDRESS 1631

Orleans St.

No other abnormal condition than cold and draught.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*,

meninges, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Haemorrhage,</i>	<i>Meningitis,</i>	<i>Phlebitis,</i>
<i>Cellulitis,</i>	<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Pyæmia,</i>
<i>Childbirth,</i>	<i>Gastritis,</i>	<i>Necrosis,</i>	<i>Septicæmia,</i>
<i>Convulsions,</i>	<i>Erysipelas,</i>	<i>Peritonitis,</i>	<i>Tetanus,</i>

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions (if induced)*, whether death is directly or indirectly due to the same.

D 67342 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67342

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *8* Ward)

Registered No. C.....

2. FULL NAME

(Residence in Baltimore: No. *2011 Keyser* St.; yrs. *3* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX

Female

4. COLOR OR RACE

*Black*5. Single,
Married,
Widowed,
or Divorced.
(Write the word.)
Married

6. DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7. AGE

48

yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8. OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

Housemaid
*270*9. BIRTHPLACE,
(State or Country).*North Carolina*10. NAME OF
FATHER,*Lewis Stone*11. BIRTHPLACE
OF FATHER,
(State or Country).*North Carolina*12. MAIDEN NAME
OF MOTHER,*Lucy Jones*13. BIRTHPLACE
OF MOTHER,
(State or Country).*North Carolina*

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

John Watson (son)
2011 Keyser St

15.

Filed

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Registrar

CORONER'S CERTIFICATE OF DEATH.

16. DATE OF DEATH

*Sept 1*1922
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* and that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

*Probably Tubercular Meningitis*CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

Pulmonary Lesion

(Signed)

J. S. F. Baker M. D.
(Coroner.)9-2-1922 (Address) *508 E. W. St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Windsor M. C.**Sept 4* 1922

20. UNDERTAKER

ADDRESS

*Edward Brown**Orleans St*

N. B.—Every item of information should be carefully supplied. Notations on back of certificate. See instructions on back of certificate.

D 67343

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D 67343

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2822 Parkwood Ave., ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Abraham Freedenberg

(a) RESIDENCE NO. 2822 Parkwood Ave., ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Whitw 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 65 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)14 Informant J. Lewis
(Address) 1439 E. Balto. St.

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1922, to Sept 5, 1922, that I last saw him alive on Sept 5, 1922, and that death occurred, on the date stated above, at 10.15 P.m.

The CAUSE OF DEATH* was as follows:

Coronary of the liver

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. Lloyd, M. D.

, 19 (Address) 2232 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Washington Road

DATE OF BURIAL

9-6-1922

20 UNDERTAKER

Jack Lewis

ADDRESS

1439 E. Balt

Physicians should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

67344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 67344

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Univ. Hospital* ST. *27* WARD)

2-FULL NAME

John Dermott

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *5501 Winner Ave.* ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *80* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed,

or Divorced (write the word)

*single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1842

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*80 yrs.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Farmer 80*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

*P. O. Bland*9 BIRTHPLACE (city or town)
(State or country)*Maryland*

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant
(Address)*P. O. Bland
5501 Winner Ave*

15

Filed

19

SEP 6 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *September 5 1922*

17

I HEREBY CERTIFY, That I attended deceased from
Sept. 3 1922, to *Sept 5* 1922that I last saw him alive on *Sept 5* 1922and that death occurred, on the date stated above, at *2:45 P. M.*

The CAUSE OF DEATH* was as follows:

*Chronic Myocarditis*CONTRIBUTORY
(Secondary)*not known*
(duration) yrs. mos. ds.*Bilateral Broncho-
pneumonia*
(duration) yrs. mos. *4* ds.18 Where was disease contracted
if not at place of death? *5501 Winner ST.*Did an operation precede death? *no* Date of _____Was there an autopsy? *no*

What test confirmed diagnosis?

*Clinical course +
laboratory*

(Signed)

J. P. Jones M. D.19 Address *University Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*David Ridge Co.**Sept 7 1922*

20 UNDERTAKER

ADDRESS

*Wm. J. Pickner & Sons**Dorchester*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

ORE ✓
159-002
D 67345

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Andrychowicz

(a) RESIDENCE NO. 822 S Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1922

Male	white	Single
------	-------	--------

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19 1922

7 AGE	Years	Months	Days	If LESS than 1 day,hrs ormin.
			17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work—

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

10 NAME OF FATHER Anthony Andrychowicz

II BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER *Catherine Maffei*

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Anthony Andrychowicz
(Address) 232 Al Bond

Filed 19 _____ Registrar

17 I HEREBY CERTIFY, That I attended deceased from
Sept 4, 1922, to Sept 5, 1922
that I last saw him alive on Sept 5, 1922
and that death occurred, on the date stated above, at 7 p.m.
The CAUSE OF DEATH* was as follows:

Conjunctival Weakness

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death?..... Date of

What test confirmed diagnosis _____ M. D.
(Signed) _____
19__ (Address) _____

*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL	DATE OF BURIAL

NAME *Holy Rosary* SEX *F* 19
ADDRESS

John M. Weber 1893 Bas
St

D 67346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67346

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD 6)2. FULL NAME Chauncey R. Lester(a) RESIDENCE NO. 1757 E. Jefferson st. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced
HUSBAND of Mollie Lester
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18797 AGE 43 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland10 NAME OF FATHER Jos. R. Lester11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Genetto Day ?13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital records
(Address) M.T.H.

SEP 6 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5, 192217 I HEREBY CERTIFY, That I attended deceased from June 30, 19 22, to Sept. 5, 19 22.that I last saw him alive on Sept. 5, 19 22.and that death occurred, on the date stated above, at 9.50 a.m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis(duration) 1 yrs. 8 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown
if not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B. in sputum, X-ray

(Signed)

Francis L. Dadoqliacca D.
9-5-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Louisa Park 9/1/22 19

20 UNDERTAKER

Mrs. Cook, 502 E. North Ave.state
CUPA-
PHYSICIAN
Exact statement
of certificates.
AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

D 67347

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67347

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 Hollins ST., 18 WARD)

2-FULL NAME

Peter Thomas Volz

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1228 Hollins

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 11 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ada

Volz

6 DATE OF BIRTH (month, day, and year)

Sept 28

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

82

11

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Peter T Volz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Prussia

12 MAIDEN NAME OF MOTHER

Myers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

PARENTS

14 Informant (Address)

Mrs Ada Volz 1228 Hollins

15

Filed, 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1922

17

I HEREBY CERTIFY, That I attended deceased from 9/2/22, 19 to 9/5/22, 19 that I last saw him alive on 9/5/22, 19 and that death occurred, on the date stated above, at 2:40 pm. The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Ch. and Hypertension

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Smith, M. D. 9/6/22 (Address) 1302 N. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Westminster

20 UNDERTAKER

H. M. Routson

DATE OF BURIAL

Sept 7 1922

ADDRESS

2238 W. Hollins

D 67348

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67348

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 110 Scott St St. 18 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 110 Scott St St.; yrs.,..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-Single, Married, Widowed, or Divorced. (Write the word.)

Married

6-DATE OF BIRTH

Jun
(Month)1
(Day)1888
(Year)

7-AGE.

34 yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Routery + Machinist

9-BIRTHPLACE.

(State or Country).

Baltimore Md

10-NAME OF FATHER.

Ernest Conrad

11-BIRTHPLACE OF FATHER. (State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Clara Conrad

13-BIRTHPLACE OF MOTHER. (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clara Conrad(Address) 110 Scott St

15-

Filed SEP 6-1922 192H. A. M.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept
(Month)4
(Day)1922
(Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

And that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart(Duration) Don't know ds.

CONTRIBUTORY (Secondary)

Don't know(Signed) H. A. M. M. D.

Coroner.

9-6-1922 (Address) 117 W. Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Landen ParkSept 7-1922

20-UNDERTAKER.

ADDRESS

H. B. Branning517 N. Calver St

D 67349

HEALTH DEPARTMENT—CITY OF BALTIMORE

67349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 935 N. Castle ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Heyman (Heyman)(a) RESIDENCE. NO. 935 N. Castle ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 9 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER Karl Heyman11 BIRTHPLACE OF FATHER (city or town) New York (State or country) N.Y.12 MAIDEN NAME OF MOTHER Frances Rush13 BIRTHPLACE OF MOTHER (city or town) New Orleans (State or country) La.14 Informant Karl Heyman (Address) 935 N. Castle St.15 Filed SEP 6 - 1922 Registrar WAW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6, 192217 HEREBY CERTIFY, That I attended deceased from Sept 6, 1922 to Sept 6, 1922 that I last saw her alive on Sept 6, 1922and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Mal-nutrition,CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 21 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis A. M. Krause M. D. 19 (Address) 2500 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Trinity Church Sept 6, 1922

20 UNDERTAKER ADDRESS

Geo M. Tuckson 811 N. W. St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 67350

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 n Bond ST. 6 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 519 n. Bond St. 6 yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Cork

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
widow

6-DATE OF BIRTH.

Aug 1 (Month) 1 (Day) 1922 (Year)

7-AGE.

70

If LESS than 1 day,

yrs. 0 mos. 0 ds. hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

House work

(b) General nature of industry, business, or establishment in which employed (or employer).

House work

9-BIRTHPLACE, (State or Country).

Maryland

10-NAME OF FATHER.

Larson Giler

11-BIRTHPLACE OF FATHER (State or Country).

Md

12-MAIDEN NAME OF MOTHER

Barbara Thomas

13-BIRTHPLACE OF MOTHER (State or Country).

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Scott(Address) 519 Bond St

SEP 6 - 1922

Filed 191 H. H. H.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 3 27 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 5 1922, to Sept 3 1922, that I saw her alive on Aug 21 1922, and that death occurred, on the date stated above, at 8 1/2 a.m. The CAUSE OF DEATH* was as follows:Chronic Interstitial
nephritis
(Duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(Signed) R. J. Young M. D.
9/6 1922 (Address) 129 E. Wisconsin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 1 mos. 1 ds. In the State 1 yrs. 1 mos. 1 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Ashbury Cemetery Sept 6 1922

20-UNDERTAKER

ADDRESS

Mrs Robert A. Elliot 1725

D 67351 HEALTH DEPARTMENT—CITY OF BALTIMORE

78 D 67351

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1224 N. Asquith St. 10 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma M. Wilson

(Residence in Baltimore: No. 1224 Asquith St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, May 25, 1870 (Month) (Day) (Year)

7-AGE, 52 yrs. 14 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, John T. Wilson

11-BIRTHPLACE OF FATHER, (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Rebecca L. Wynn

13-BIRTHPLACE OF MOTHER, (State or Country), Balto Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Rebecca Wilson

(Address) 1224 Asquith

SEP 6 - 1922

Filed 1922

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Cause, Epilepsy since Childhood

CONTRIBUTORY (Secondary) (over)

(Signed) J. H. Pate M. D.

(Coroner) Sept 2, 1922 (Address) 508 E North

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

London Park Cemetery Sept 5, 1922

20-UNDERTAKER, ADDRESS

Henry Hood & Son 1301 E Eager

D 67352 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 944 N. Castle ST., 7 WARD)

2-FULL NAME

(a) RESIDENCE NO. 944 N. Castle ST., WARD (If non-resident give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 9/4/22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Louis Bateman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Loretta Hedges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Louis Bateman (Address) 944 N. Castle St.

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6 1922

17 I HEREBY CERTIFY, That I attended deceased from 9-4 1922, to 9-6 1922, that I last saw him alive on 9-5 1922, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Sustained close
Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) M. J. Hedges, M. D.

19 (Address) 500 N. Main St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New City Cem 9/7/22

20 UNDERTAKER Geo. J. Putt 135 Hopedale

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67353

HEALTH DEPARTMENT—CITY OF BALTIMORE

67353

CERTIFICATE OF DEATH.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.;yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed

SEP 6 - 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

..... 1922, to 1922,

that I saw him alive on 1922,

and that death occurred, on the date stated above, at P.M.

The CAUSE OF DEATH* was as follows:

.....
.....
.....

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed)..... M.D.

....., 1922. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

.....

....., 1922.

20-UNDERTAKER

ADDRESS

.....

.....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67355

D 67355

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Keyworth Ave. W. MARR 15* ST. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode) *Keyworth Ave. W. Md. Railroad* ST. *15* WARD. (If nonresident give city or town and State)Length of residence in city or town where death occurred yrs. *6* mos. *13* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 24 + 922*7 AGE Years *6* Months *12* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 6 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 20*, 1922, to *Sept 6*, 1922, that I last saw him alive on *Sept 5*, 1922, and that death occurred, on the date stated above, at *8:30 A.M.*

The CAUSE OF DEATH* was as follows:

*Cholera Infantum
complicated more or less
for past 3 weeks*(duration) yrs. mos. *17* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *1* ds.

18 Where was disease contracted

if not at place of death? *at residence alone*Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Chas A Fetterhoff* M. D., 19 (Address) *1207 W North Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys Hospital Sept 7 1922

20 UNDERTAKER ADDRESS

A S Marshall 3539 Fall Road

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

P6-1922

Burial Permit Clerk

D 67356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1)

2-FULL NAME

(Residence in Baltimore: No. 417 N. Chester St.)

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 11th, 1857 (Month) (Day) (Year)

7-AGE, 65 yrs. 4 mos. 7 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Merchant. (b) General nature of industry, business, or establishment in which employed (or employer), Merchant & Business Transportation Co.

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, John J. Dressel.

11-BIRTHPLACE OF FATHER (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Elizabeth Miller.

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary G. Dressel

(Address) 417 N. Chester St.

15- Robert P. Harrison, Registrar.

1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5 - 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) M. D. M. D. (Coroner) 1037 E. 7th St., 1922 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, 7 yrs. 10 mos. 7 ds. State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Baltimore Md. Sept 7, 1922

20-UNDERTAKER, ADDRESS, Mrs. C. Miller 2334 Jefferson St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67357

CERTIFICATE OF DEATH.

D 67357

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 Lemon ST., 19th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

67 yrs.

5 mos.

ds.

How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Sept 2, 1922, to Sept 5, 1922, that I last saw him alive on Sept 4, 1922, and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

9/6, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative bealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Apoplectic
Cerebral hemorrhage

D 67358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1290 D 67358

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Whatcoat ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anne E. Young

(a) RESIDENCE. NO.

1118 Whatcoat ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 20-1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42913

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

Mary Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Wm Young
1118 Whatcoat

15

Filed SEP 7-1922, 19J E Vehn

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 15, 22 to Sept 4, 22that I last saw him alive on Sept 3, 22and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Subacute Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? urinalysis(Signed) H. S. McCard, M. D.9/5, 1922 (Address) 2008 Duffell Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Louise CemeterySept 7 19 22

20 UNDERTAKER

John H. Owens

ADDRESS

538 Duffell Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67359

D 67359

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N Port St ST., 8 WARD)

2. FULL NAME

Edward Smith

(a) RESIDENCE NO.

1618 N Port StST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

the late Mary Smith

6 DATE OF BIRTH (month, day, and year)

April 23 1852

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Night watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

62

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balta Md.

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant
(Address)Elizabeth Morphet
1618 N Port St

15

Filed 1922

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5th 1922

17

I HEREBY CERTIFY, That I attended deceased from

8-21, 19 22 to 9-5, 19 22

that I last saw him alive on

9-5, 19 22and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis
(Isitic)(duration) 2 yrs. 0 mos. 0 ds.CONTRIBUTORY
(Secondary)Gumma of Liver(duration) 1 mo. 16 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of Was there an autopsy? NoWhat test confirmed diagnosis? Clinical history(Signed) S. Druggs, M. D., 19 (Address) 1604 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Baltimore Cemetery Sept 8, 19 22

20 UNDERTAKER

ADDRESS 1441Robert J. Turner 1441 Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67360

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2150 Washington Road ST. WARD)

2. FULL NAME Melhemus Hale

(a) RESIDENCE NO. 2150 Washington Road ST. WARD

(Usual place of abode) Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Hale

6 DATE OF BIRTH (month, day, and year) Oct. 10 1853

7 AGE 68 Years Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none 137

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ind (State or country)

10 NAME OF FATHER unknown Long

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Lena White (Address) 2150 Washington Road

15 Filed 1922 Registrar

REGISTERED NO.

D 67360

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-5-1922

17 I HEREBY CERTIFY, That I attended deceased from 8-31-1922 to 9-5-1922

that I last saw him alive on Sept 5, 1922

and that death occurred, on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) M. D.

, 19 (Address) Halethorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Linden Park

Sept 7 1922

20 UNDERTAKER

ADDRESS

St. M. Cork

N. & S. M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67361

CERTIFICATE OF DEATH.

D 67361

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Mount ST., 16 WARD)

2-FULL NAME

John Riley

(a) RESIDENCE NO.

Morrow Hospital

(Usual place of abode)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced, (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

37

Years

Months

Days

If LESS than
1 day,hrs.
ormin.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workClerk(b) General nature of industry,
business, or establishment in
which employed (or employer)Seafaring

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Canada

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant

(Address)

Taken from History

SEPT-1-1922

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 5 19 22

17

I HEREBY CERTIFY, That I attended deceased from

8/7, 19 22, to 9/5, 19 22.that I last saw him alive on 9/5, 19 22.and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH was as follows:

Typhoid FeverCONTRIBUTORY (Secondary) Parasites
(duration) yrs. 1 mos. ds.(duration) yrs. mos. 2 ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Widal & Cultures(Signed) P. E. Schoole, M. D., 19 (Address) Morrow Hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVALTrinity CemeteryDATE OF BURIAL Sept 7 19 22

20 UNDERTAKER

J. J. JohnsonBro E. B. Ballist

D 67362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 404 So. Collington Ave Ward)

Registered No. C.....

2-FULL NAME... Eva Rutkowski

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 404 So. Collington Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White5-Single,
Married,
Widowed,
or Divorced.
(Write the word.)Single

6-DATE OF BIRTH.

Sept 6

1922

7-AGE.

2 yrs. mos. ds.

If LESS than 1 day,

2 hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).

Food9-BIRTHPLACE.
(State or Country).Balto, Md

10-NAME OF FATHER.

Julius Rutkowski11-BIRTHPLACE OF FATHER.
(State or Country).Poland

12-MAIDEN NAME OF MOTHER.

Bertha Polonoski13-BIRTHPLACE OF MOTHER.
(State or Country).Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Bertha Rutkowski

(Address).

404 So. Collington Ave

SEP 7 - 1922

1922

Ham

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 6

1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said Inquiry
(Inquest, autopsy or inquiry.)and that said deceased came to death
(Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) John M. Weber M. D.Sept 6 1922 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or, in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Calvary Rosary Sept 7 1922

20-UNDERTAKER,

ADDRESS

John M. Weber 1803 Bank

D 67363

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 67363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 2 mos. 1 ds.

How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mr. Soule

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country)

Baltimore Md.

10 NAME OF FATHER

Frederick Soule

11 BIRTHPLACE OF FATHER (city or town)

Lyon France

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

Paris France

14

Informant (Address)

Records of Mt Hope Retm

SEP 7 - 1922

H. A. W.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 6, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 11, 1921, to Sept 6, 1922

that I last saw him alive on Sept 5, 1922

and that death occurred, on the date stated above, at 10.25 A.M.

The CAUSE OF DEATH* was as follows:

Paras - (Chcif)

abs

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

Paramed

abs

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted

if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery M. D.

Sept 6, 1922 (Address) Mt Hope Retm

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Landon Park Cemetery Sept 8, 1922

20 UNDERTAKER

ADDRESS

Jos Joerden 2178 Bay

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67364

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67364

CERTIFICATE OF DEATH.

31✓

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

Church St Road

ST. 25 WARD)

2. FULL NAME

Blyde Connor

(a) RESIDENCE NO.

Church St Road

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs. 7 mos. 22 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan, 15, 1903

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

19

7

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 040

(h) General nature of industry, business, or establishment in which employed (or employer)

Fertilizer

(c) Name of employer

Standard, Curtis Bay

9 BIRTHPLACE (city or town) (State or country)

Caroline Co. Virginia

10 NAME OF FATHER

Henry Davenport

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ashtand Virginia

12 MAIDEN NAME OF MOTHER

Lucy Connor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Caroline Co. Virginia

14

Informant (Address)

Lorena Connor 1124 Clarkson St

15

Filed

19

SEP 7 - 1922

H. A. [Signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 6, 1922

17

I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1922, to Sept, 6, 1922.

that I last saw him alive on Sept, 5, 1922.

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) - yrs. 9 mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 51 W. West St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Positive sputum

(Signed) David Franklin, M. D.

9/6, 1922 Address 1124 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Furnace Branch

DATE OF BURIAL

Sept 8 1922

20 UNDERTAKER

John F. Denny

ADDRESS

715 Light St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 67365

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67365

CERTIFICATE OF DEATH

1-PLACE OF DEATH

St. Agnes Hosp. Balt. Md

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Rev. Francis B. McKenna

(a) RESIDENCE NO.

50 Jefferson Ave. Ellicottown Pa

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

23 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 15 1876

7 AGE

46

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Priest

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pittsburg, Pa.

10 NAME OF FATHER

John Gurnea

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Mary Gurnea

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pittsburg, Pa.

14

Informant (Address)

St. Agnes Hosp. Balt. Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/7/ 19 22

17

I HEREBY CERTIFY, That I attended deceased from

June 14, 19 22, to Sept 7, 19 22

that I last saw him alive on Sept 6, 19 22

and that death occurred, on the date stated above, at 12 40 A. M.

The CAUSE OF DEATH* was as follows:

Inoperable carcinoma of the sigmoid

first symptoms April 11, 19 22 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/19/22

Was there an autopsy? no

What test confirmed diagnosis? Surgical Pathology

(Signed) H. Harper M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Corryville, Pa.

20 UNDERTAKER

G. B. Shippert 2236 Fudh, Pa.

DATE OF BURIAL

Sept 7 19 22

ADDRESS

Physician's statement should be stated EXACTLY. Exact statement should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

SEP 7 - 1922

Filed

19

Registrar

D 67366 HEALTH DEPARTMENT—CITY OF BALTIMORE 67366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1145 E. Lombard St. 3 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1145 E. Lombard St.; yrs. 75 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH

(Month) (Day) (Year)

7-AGE

75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

SEP 7 - 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Signed) (Coroner)

1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, State (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS

May Larson Baltimore

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67367

CERTIFICATE OF DEATH.

D 67367

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 62 Sohrs Lane ST. 20 WARD)

2-FULL NAME

(a) RESIDENCE (No. 62 Sohrs Lane ST. 20 WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 75 Months 0 Days 0 If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Cement Carrier

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. Md (State or country)

10 NAME OF FATHER Edward Weeks

11 BIRTHPLACE OF FATHER (city or town) Howard Co., Md (State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Howard County Md (State or country)

14 Informant Lezzi Ramsey (Address) 62 Sohrs Lane

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1922

17 I HEREBY CERTIFY, That I attended deceased from 8/1 1921 to 9/5 1922

that I last saw him live on 9/3 1922

and that death occurred, on the date stated above, at 4:55 P. m.

The CAUSE OF DEATH* was as follows:

Senile arterio-sclerosis with hypertension

(duration) 1 yrs. 1 mos. 0 ds.

CONTRIBUTORY Angina pectoris (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? 62 Sohrs Lane

Did an operation precede death? No Date of 9/8/22

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physiological

(Signed) Samuel P. Abney, M. D.

, 19 22 (Address) 3316 Frederick St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Wesley Star cemetery DATE OF BURIAL Sept 8 1922

20 UNDERTAKER Edward W. Pyle ADDRESS 103 E. Howard

Catonsville

P 7-1922

, 19

Registrar

PLACE OF DEATH
D 67868
County

Village or City

2 FULL NAME

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Sept 6 1922 (Month) (Day) (Year)

7 AGE 4 yrs. X mos. X ds. If LESS than 1 day, 4 hrs. OR min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Chas. H. Smith

11 BIRTHPLACE OF FATHER No

12 MAIDEN NAME OF MOTHER Laura Browning

13 BIRTHPLACE OF MOTHER Balto. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. H. Smith

(Address) Dundalk, Md.

15

1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 6 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 1922 to Sept 6 1922

that I last saw him alive on 191

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH * was as follows:

Premature birth (7 1/2 mos.)

Contributory Secondary

(Signed) W. McCarroll 8/7 1922 (Address) Dundalk, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted? If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20 UNDERTAKER Cedar Hill ADDRESS

67 M. McCarroll 528 Dundalk

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V.S. No. 1

D 67369 HEALTH DEPARTMENT—CITY OF BALTIMORE 67369

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Dunn(a) RESIDENCE NO. 1013 Albermarle St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18547 AGE Years 68 Months -- Days -- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant Hospital Records,
(Address) Municipal Hospital.

SEP 7 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1922

17

I HEREBY CERTIFY, That I attended deceased from September 3, 1922, to September 3, 1922.that I last saw him alive on September 3, 1922.and that death occurred, on the date stated above, at 2 P.M. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 10 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clayton M. Neel M. D.9/7/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health

SEP 7 - 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE 67370

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Washington(a) RESIDENCE NO. 1024 Granberry St ST. 3 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 18677 AGE Years Months Days If LESS than 1 day, hrs. or min. 55 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Walter Washington11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant Hospital Records,(Address) Municipal Hospital UNIVERSITY OF MARYLAND15 Filed SEP 7-1922 19 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 19 2217 I HEREBY CERTIFY, That I attended deceased from June 30, 19 22, to September 5 19 22, that I last saw him alive on September 5, 19 22, and that death occurred, on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. H. M. M. M. M. D.9/7/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

SEP 12 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67371

D 67371

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *Municipal Ex Hosp. 22* WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.

WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Col.

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

8 LESS than
1 day, hrs.
or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed 1922, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, that I attended deceased from
Apr 28 19*22* to *Sept 4* 19*22*,
that I last saw him alive on *Sept 4* 19*22*
and that death occurred, on the date stated above, at *5:45* a. m.

The CAUSE OF DEATH* was as follows:

*Pulmonary Tuberculosis*CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

State
PA-
Exact statement of
Physician should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

UNIVERSITY OF MARYLAND

BEP 1123

D 67372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Miller(a) RESIDENCE No. Va. House, Light and Lee St. WARD(Usual place of abode) Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated6 DATE OF BIRTH (month, day, and year) 18447 AGE Years 78 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Alfred Miller11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Charity Holland13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant: Hospital Records (Address) M.T.H.15 Filed SEP 7-1922 19 19195 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 19 2217 I HEREBY CERTIFY, That I attended deceased from July 24, 19 22, to Sept. 5, 19 22 that I last saw him alive on Sept. 5, 19 22 and that death occurred, on the date stated above, at 12 05 a.m. The CAUSE OF DEATH* was as follows:Pulmonary tuberculosis(duration) yrs. 9 mos. ds.CONTRIBUTORY Syphilis (Secondary) (duration) Unknown yrs. mos. ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis L. Dabapliaca M. D. 9-5-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS SEP 7-1922

D 67373

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67373

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2922 Jefferson St., 7 WARD)

2-FULL NAME

Mary J. Sanderling

(a) RESIDENCE NO.

2922 Jefferson St., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

John H. Sanderling

6 DATE OF BIRTH (month, day, and year)

June 7-1895

7 AGE

87

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Thomas H. Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Ann F. Tanaga

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant

(Address)

Kathryn Goldbeck 2922 Jefferson St.

15 SEP 7 - 1922

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 6th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 2, 1919, to Sept 6, 1922

that I last saw him alive on Sept 6, 1922

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration)

3

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Green Mount Cemetery

Sept 9 1922

20 UNDERTAKER

Miss C. Miller

ADDRESS

2334 Jefferson St.

D 67374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67374

CERTIFICATE OF DEATH.

113
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Presstman ST. 15 WARD)

2-FULL NAME

Elmore Nathan Boswell

(a) RESIDENCE NO.

1424 Presstman ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 27, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Ind.

10 NAME OF FATHER

Chester Boswell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Ind.

12 MAIDEN NAME OF MOTHER

Deba McKenney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Deba Boswell 1424 Presstman St.

Filed

SEP 7-1922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 5, 1922, to Sept 5, 1922.

that I last saw him alive on Sept 5, 1922.

and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Bronchial Pneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

William F. Fry, M. D.

9/5, 1922 (Address)

1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mt Auburn

James J. Denins

1303 Presstman St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67375

67375

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 N. Calvert ST., 12 WARD)2-FULL NAME Elizabeth Wheeler(a) RESIDENCE No. 3006 N. Calvert ST., 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 22 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced

(or) WIFE of James C. Wheeler6 DATE OF BIRTH (month, day, and year) Oct 15 1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 67 10 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)10 NAME OF FATHER Henry Covington11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)12 MAIDEN NAME OF MOTHER Elizabeth Will13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14

Informant Mr Joseph M. Fowler
(Address) 3006 N. Calvert St

15

Filed

Robert F. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1919, to Sept 6, 1922.that I last saw him alive on Sept 5, 1922.and that death occurred, on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Filoid
Tuberculosis(duration) 20 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? noWhat test confirmed diagnosis? Phys. Exam.(Signed) Hanson & Beach

M. D.

Address 20 E. Presler St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cemetery

DATE OF BURIAL

Sept 9 1922

20 UNDERTAKER

George Schilling & Sons

ADDRESS

1126 Monument St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67376		HEALTH DEPARTMENT—CITY OF BALTIMORE	
1-PLACE OF DEATH		CERTIFICATE OF DEATH.	
City of BALTIMORE: (No. 140 S. Wilkens St., 20 Ward)		Registered No. C. 179 D 67376	
2-FULL NAME James Crilley		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
(Residence in Baltimore: No. 140 S. Wilkens St., 20 yrs., mos., ds.)			
PERSONAL AND STATISTICAL PARTICULARS.			
3-SEX, male	4-COLOR OR RACE, white	5-Single, Married, Widowed, or Divorced, Single	
6-DATE OF BIRTH, (Month) (Day) 1873 Year			
7-AGE, 49 yrs., mos., ds.	If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Elevator operator (b) General nature of industry, business, or establishment in which employed (or employer), W. Ind R.R.			
9-BIRTHPLACE, (State or Country), Texas Ind			
PARENTS.	10-NAME OF FATHER, Henry Crilley		
	11-BIRTHPLACE OF FATHER, (State or Country), Ireland		
	12-MAIDEN NAME OF MOTHER, Mary Kennedy		
	13-BIRTHPLACE OF MOTHER, (State or Country), Ireland		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Henry Crilley (Address) Long Green Bats G			
15- Robert P. Harrison, Registrar. Filed 1922 Serial Permit Clerk.			
CORONER'S CERTIFICATE OF DEATH.			
16-DATE OF DEATH, Sept 7, 1922 (Month) (Day) (Year)			
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.			
The CAUSE OF DEATH* was as follows: Acute Nephritis following chronic			
CONTRIBUTORY (Secondary) Acute Dilatation of heart (Duration) 2 yrs., mos., ds.			
(Signed) James M. Newton, M. D. (Coroner.) Sept 7, 1922 (Address) 700 E. Chase St.			
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.			
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs., mos., ds. In the State, yrs., mos., ds.			
Where was disease contracted, if not at place of death?			
Former or usual residence			
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Long Green Bats Co. Md. Sept 7, 1922			
20-UNDERTAKER, STEWART & MOYEN COMPANY (WILLIAM F. WOODEN Successor) ADDRESS			

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67377

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *831 Hamilton Terrace* WARD)2-FULL NAME *Newton Michie Gray*(a) RESIDENCE. No. *831 Hamilton Terrace* ST. WARD.(Usual place of abode) Length of residence in city or town where death occurred *56* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1847*7 AGE Years *75* Months Days If LESS than 1 day... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Leesburg Va.* (State or country)10 NAME OF FATHER *Asher Waterman Gray*11 BIRTHPLACE OF FATHER (city or town) *Virginia* (State or country)12 MAIDEN NAME OF MOTHER *Martha Luckett*13 BIRTHPLACE OF MOTHER (city or town) *Virginia* (State or country)14 Informant *Miss Jessie Gray* (Address) *831 Hamilton Terrace*15 Filed *1922* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sep. 6* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Jan 24* (*24*) 19 *22*, to *Sep. 6* 19 *22*, that I last saw him alive on *Sep. 6* 19 *22*and that death occurred, on the date stated above, at *8.30 P.* m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage occurring on Jan 24(duration) yrs. *7* mos. ds.

CONTRIBUTORY

(Secondary) *Dianthous* (duration) yrs. mos. *3* ds.18 Where was disease contracted *831 Hamilton Terrace* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Examing the patient*(Signed) *Nellie V. Mark* M. D., 19 (Address) *1318 Linden Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Green Mount Cem *Sept 9* 19 *22*

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Marks 1318 Linden

D 67378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H9D 67378

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 679 S. Third St. ST., 16 WARD)

2-FULL NAME

Barbara Snarely.

(a) RESIDENCE NO.

679 S. Third St.

ST., 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

15 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married.

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Benjamin F. Snarely.

6 DATE OF BIRTH (month, day, and year)

Aug. 8-1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

0

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Co. Md.

10 NAME OF FATHER

John H. Butschky.

11 BIRTHPLACE OF FATHER (city or town)

Germany.

(State or country)

12 MAIDEN NAME OF MOTHER

Louisa Lang.

13 BIRTHPLACE OF MOTHER (city or town)

Germany.

(State or country)

14

Informant (Address)

Benjamin F. Snarely 679 S. Third St.

15

Filed

19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 15, 1922, to Sept 5, 1922,

that I last saw her alive on Sept 5, 1922,

and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Kidney

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Metastasis in Lung

(duration) yrs. mos. 15 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of Aug 10 1922

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Herman B. Titbans, M. D.

1922 (Address) 315 S. Highland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cemetery

DATE OF BURIAL

Sept 8 1922

20 UNDERTAKER

Lilly Ed Zeller.

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67379

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 518 S. Bond ST. 3 WARD)

2. FULL NAME Julia Budzinski

(a) RESIDENCE NO. 518 S. Bond ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 22 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 16-22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 6 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER James Budzinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Pauline Musumeci

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Julia Budzinski (Address) 518 S. Bond

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 4 1922, to Sept 6 1922, that I last saw her alive on Sept 6 1922, and that death occurred, on the date stated above, at 9 P. M. The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 Alameda

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Rosary.

Sept 8 1922

20 UNDERTAKER

ADDRESS

11-11-11 Fairview 1618 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

7-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67380

D 67380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Hebrew Hospital
Monument & Rutland Ave ST.

WARD) 1

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

Mr. Stanislaw Gieron

(a) RESIDENCE. NO.

1010 S. Potomac

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

31 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)

married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE ofKatharine Gieron
unknown

6 DATE OF BIRTH (month, day, and year)

56 59 00

7 AGE Years Months Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Pyre Fitter

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Poland

10 NAME OF FATHER

Frank Gieron

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Mary Mikrut

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Poland

14

Informant
(Address)Katharine Gieron
1010 S. Potomac

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 27, 1922, to Sept 5, 1922,

that I last saw him alive on Sept 5, 1922,

and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY
(Secondary)

Cause of emphysema & heart failure

(duration) yrs. 3 mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Yes Date of Aug 29, 22

Was there an autopsy? Yes

What test confirmed diagnosis? Appropriate

(Signed) Leonard Greenbaum M.D.

9/6, 1922 (Address) 7173 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus

Sept 9 1922

20 UNDERTAKER

ADDRESS

J. Halkowski 1000 Newwood Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1922

Burial Permit No.

BALTIMORE STEAM PACKET COMPANY
(OLD BAY LINE)

S. A. MORTIMER, AGENT

BALTIMORE, MD.,

D 673

J. Louis A. Gieron, a Notary Public of
State of Maryland, in and for Baltimore City
personally appeared before me, Catherine Gier
alleges and says that best to her knowledge and
belief her husband Stanislaw Gieron, deceased
at the time of death was 56 years old and
59 years, as reported by her on September 7th 1922.

Catherine ^{her} Gieron
mark

Subscribed and sworn to before me, this 12th
of September 1922, the same having been by me
to this affiant, she being illiterate, and understanding
same.

Louis A. Gieron

Notary Public

My Commission expires May 5, 1924

15-8227
D 67381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 67381

1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL 25

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2. FULL NAME

Mr. Willard Stanford Efinsker

(a) RESIDENCE NO.

1510 Graham Court, Curtis Bay Balto. Md.

(Usual place of abode)

Length of residence in city or town where death occurred

Unknown

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Sophie T. Efinsker (WIFE)

6 DATE OF BIRTH (month, day, and year)

Sept 11 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

29 11 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Penna.

10 NAME OF FATHER

Harry Efinsker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penna.

12 MAIDEN NAME OF MOTHER

Lula Ward

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Penna.

14

Informant

JOHNS HOPKINS HOSPITAL

(Address)

Bessie

15

Robert F. Harrison

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 5th 1922 to Sept 6 1922

that I last saw him alive on Sept 6 1922

and that death occurred, on the date stated above, at 10:50 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary)

(duration) 3 1/2 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R. Bugg M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Sewsburg, Pa.

20 UNDERTAKER

Wm Cook

DATE OF BURIAL

9-9-1922

ADDRESS

502 E. North

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P7-1922

D67382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67382

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *677^E Clements* ST. *7th* WARD)2-FULL NAME *Anna Maria Gibson*

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *677^E Clements* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. — mos. — ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced

(or) WIFE of *Richard C. Gibson*6 DATE OF BIRTH (month, day, and year) *Feb. 17, 1888*

7 AGE

Years *64*Months *6*Days *20*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife, good*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Nelson C. Va.*
(State or country)10 NAME OF FATHER *John Corley*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *unknown*12 MAIDEN NAME OF MOTHER *Elizabeth Kennedy*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *unknown*

14

Informant *Sarah E. Gibson*(Address) *734 C. Hazlett St.*

15

-1922

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 7, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Aug. 30, 1922, to Sept. 7, 1922,*that I last saw him alive on *Sept. 6, 1922,*and that death occurred, on the date stated above, at *12 A. M.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(duration) *unknown* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *urinary*(Signed) *W. J. Seabury*

M. D.

9/7, 1922 Address *628 Fosh*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Charlottesville Va**9/8" 22*

20 UNDERTAKER

ADDRESS

E. J. Cunningham & Son Wash. St. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67383

1-PLACE OF DEATH

City of BALTIMORE: (No. *22. P. I.* St. *15* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1606 N. Gilman St.* St.; yrs. *1* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced, (Write the word) *Single*

6-DATE OF BIRTH *Aug. 4, 1920*
(Month) (Day) (Year)

7-AGE *2* yrs. *1* mos. *2* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country) *Balto. Md.*

10-NAME OF FATHER *Francis J. Weik*

11-BIRTHPLACE OF FATHER (State or Country) *Md.*

12-MAIDEN NAME OF MOTHER *Gertrude F. Schaefer*

13-BIRTHPLACE OF MOTHER (State or Country) *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Francis J. Weik*

(Address) *1606 N. Gilman St.*

15- Filed *SEP 8 - 1922* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept. 6, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull from fall from 3rd floor back porch
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. P. Hennessey* M. D.

(Coroner.) *Sept. 7, 1922* (Address) *2802 Edmondson Ave.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Lorraine Cemetery *Sept 8, 1922*

20-UNDERTAKER ADDRESS

Joseph Syfer 1606 W. North Ave.

15-810-2 HEALTH DEPARTMENT—CITY OF BALTIMORE

Med 67384

CERTIFICATE OF DEATH.

320 67384

1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL, ST. 25 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Julia Thomas

(a) RESIDENCE NO.

17 Para Street Mt Airy ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

✓

6 DATE OF BIRTH (month, day, and year)

Oct. 17 - 1907

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

14

10

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Aly Thomas

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Lilhe Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

SEP 8 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 5 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 21, 1922, to Sept 5, 1922,

that I last saw him alive on Sept 5, 1922,

and that death occurred, on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration)

About 2 mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Not known

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Ran, Spinal Fluid

(Signed)

Chas. Reberg

M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt Auburn

DATE OF BURIAL

Sept 8 1922

20 UNDERTAKER

John W. Toadum

ADDRESS

142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67385

CERTIFICATE OF DEATH.

167D 67385

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 758 W. Mulberry ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 758 W. Mulberry St.; yrs., 1 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single (Write the word.)

6-DATE OF BIRTH. July 15, 1922 (Month) (Day) (Year)

7-AGE. XX yrs. XX mos. 7 Wks. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). 758 W. Mulberry, Baltimore, Md.

10-NAME OF FATHER. John Gross

11-BIRTHPLACE OF FATHER. Calvert Co., Md.

12-MAIDEN NAME OF MOTHER. Ida Gray

13-BIRTHPLACE OF MOTHER. Calvert Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Gross

(Address) 758 W. Mulberry St.

15-

Filed SEP 8-1922 191 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 6, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from July 26 1922, to Sept 6 1922, that I saw him alive on Sept 6 1922, and that death occurred, on the date stated above, at 6:30 p.m.

The CAUSE OF DEATH* was as follows: Acute Hemorrhagic Disease of Childhood (Duration) XX yrs. XX mos. 12 Hrs.

CONTRIBUTORY (Secondary)

(Signed) John T. Aubrey, M. D. 9/7/22 (Address) 1629 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn DATE OF BURIAL, Sept 8, 1922

20-UNDERTAKER John H. Toadmuskil ADDRESS 142

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 67386

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1129 Whatcoat ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Carrie Means

(a) RESIDENCE. NO.

1129 Whatcoat

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofSylvester Means

6 DATE OF BIRTH (month, day, year)

April 1900

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.2255

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Annapolis Md.

10 NAME OF FATHER

David White

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Calver Co. Md.

12 MAIDEN NAME OF MOTHER

Carrie Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West River Md.

14

Informant

(Address)

Mrs. Carrie White
1129 Whatcoat St.

15

Filed

19

SEP 8 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 29th, 1922, to Sept. 5th, 1922.that I last saw her alive on Sept 5th, 1922.and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Congestion
over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of -Was there an autopsy? noWhat test confirmed diagnosis? Symptomatology(Signed) Jas Edward Bell, M. D.Address) 1224 N. Gilman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Brewer Hill A. C. CoSept 8 1922

20 UNDERTAKER

ADDRESS

Sam'l H. Chase Son1400 Market

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Possibly pulmonary tuberculosis although not reported in Murray Division

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67387
1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1407 Park Ave ST. 14 WARD)

2. FULL NAME Elizabeth Mitchell

(a) RESIDENCE No. 1407 Park Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female white single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1922

17 I HEREBY CERTIFY, That I attended deceased from

1919, to Sept 6 1922, that I last saw him alive on Sept 6 1922

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile myocarditis & coronary thrombosis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. W. Van der P. M. D.

9.6, 1922 (Address) 1515 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER ADDRESS

John O. Mitchell 1201 N. Fayette

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67388

CERTIFICATE OF DEATH.

98 D 67388

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1935 Harlem Ave. ST., 16 WARD)

2. FULL NAME

(a) RESIDENCE NO. 1935 Harlem Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of James R. Marley6 DATE OF BIRTH (month, day, and year) Feb 5 - 18597 AGE Years 63 Months 7 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md10 NAME OF FATHER Marcellus Balderston11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co., Md12 MAIDEN NAME OF MOTHER Margaret Haislett13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio14 Informant Mrs Agnes Richardson (Address) 2145 W. Sprague St15 Filed SEP 8 - 1922 Registrar [Signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 192217 I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to Sept 7, 1922, that I last saw him alive on Sept 7, 1922, and that death occurred, on the date stated above, at 415 a m.The CAUSE OF DEATH* was as follows:
Pericarditis
on endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY Endocarditis (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. E. Plummer, M. D., 19 (Address) 1641 Canton Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Louisa ParkDATE OF BURIAL SEP 9 192220 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67389 HEALTH DEPARTMENT—CITY OF BALTIMORE 67389

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3800 Reisterstown Rd. ST. WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Raymond

(a) RESIDENCE. No. 3800 Reisterstown Rd. ST. WARD.

(Usual place of abode) Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of - Angelina Tamburo (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 5 - 1860

7 AGE 62 Years 1 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Retired 13 yrs (b) General nature of industry, business, or establishment in which employed (or employer) Merchant Products (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Salvatore Raymond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmela Cuspi

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Emanuel Raymond (Address) 3800 Reisterstown Rd.

SEP 8 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15th 1922 to Sep. 7th 1922 that I last saw him alive on Sep. 6th 1922 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 2, mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Charles J. Festa, M. D. 19 (Address) 210 Earl St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cemetery Sep 19 1922

20 UNDERTAKER John H. Bowyer, Jr. ADDRESS

Res. 17 Bowyer, 901 Hollins St.

D 67390

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67390

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal HospitalST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Eliza Brown(a) RESIDENCE. NO. Unknown

(Usual place of abode)

ST. 26 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black5 Single, Married, Widowed, or Divorced (write the word)
Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown

6 DATE OF BIRTH (month, day, and year)

1856

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.66----

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore,Maryland

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Unknown

14

Informant
(Address)Hospital Records,Municipal Hospital.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 19 22

17

I HEREBY CERTIFY, That I attended deceased from
August 21, 19 16 to September 6, 1922,
that I last saw her alive on September 5, 1922,
and that death occurred, on the date stated above, at 3:00 A.M.
The CAUSE OF DEATH* was as follows:Broncho pneumoniaCONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

15 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yesWhat test confirmed diagnosis? aut

(Signed)

9/6/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

SEP 8 1922

Registrar

Laurel Key Sept 19 22
Stamley Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67391

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67391

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *22* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Matilda Chase

(a) RESIDENCE. No.

608 Iceland

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*William C. Chase*

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*30*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Georgetown*

10 NAME OF FATHER

Elijah Anderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Mary Halland

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Pa.

14

Informant
(Address)*Stephen Brooks*

15

Filed *SEP 8* 1922, 19*H. A. M. Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9-5-22

17

I HEREBY CERTIFY, That I attended deceased from

9-2, 19*22*, to *9-5*, 19*22*

that I last saw him OR alive on

9-5, 19*22*

and that death occurred, on the date stated above, at

11:30 A. m.

The CAUSE OF DEATH* was as follows:

Surgical Shock

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Sepsis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

yes

Date of

9-5-22

Was there an autopsy?

yes

What test confirmed diagnosis

fluoresc. finding

(Signed)

R. B. Jones

M. D.

19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Ambrose Cemetery

20 UNDERTAKER

ADDRESS

Frank Henry M. M. M.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Probably due
to gonococcus
infection.*

Spec. 1-10-21 M&T 1800 Bks.
Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67392

CERTIFICATE OF DEATH.

D 67392

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 Washington ST., 8 WARD)

2-FULL NAME

Charles E. Gontum

(a) RESIDENCE No.

1928 Washington ST.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs.

1 mos.

5 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of Mary A. Gontum

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 2, 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Shoe worker

(b) General nature of industry, business, or establishment in which employed (or employer)

Shoe

(c) Name of employer

Muskin Shoe Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Peter Gontum

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Maryland

12 MAIDEN NAME OF MOTHER

Mrs. Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Maryland

14

Informant

Wife - Mary A. Gontum

(Address)

1928 Washington ST.

15

Filed Sep 7, 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

September 7, 1922

17

I HEREBY CERTIFY That I attended deceased from

August 18, 1922, to September 7, 1922

that I last saw him alive on September 6, 1922

and that death occurred, on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

—

Did an operation precede death? No

Date of —

Was there an autopsy? No

What test confirmed diagnosis?

Physical Examination

(Signed)

Albert C. Gault, M. D.

(Address)

2027 E North Ave.

9-7-1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Round Park Cem

DATE OF BURIAL

Sept 11, 1922

20 UNDERTAKER

Wm. H. Kuehn

ADDRESS

North Ave.

D 67393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Maryland General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Madison - Linden Street

ST.:

WARD)

2-FULL NAME

Herman H. Vonderheide

(a) RESIDENCE. No.

2758 Tivoli

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

71 yrs. 11 mos. 19

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

6a If married, widowed, or divorced, deceased of (or) WIFE of

Mary A. Vonderheide

6 DATE OF BIRTH (month, day, and year)

Oct. 26 1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

11

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

National

(c) Name of employer

Casket Co.

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Lehard H. Vonderheide

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary E. Buscher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

George H. Vonderheide
2760 Tivoli St. - Towson, Md.

SEP 8 1922. 19

H. A. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 7th 1922

17

I HEREBY CERTIFY, That I attended deceased from

August 25, 1922, to Sept 6, 1922.

that I last saw him alive on Sept 6, 1922.

and that death occurred, on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

1. Acute Appendicitis
2. Acute Peritonitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 12 ds.

Acute Abdomen

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

Yes

Date of Aug 25-1922

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical & Operation

(Signed) James Robert Wilkerson, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cem

Sept 11, 1922

20 UNDERTAKER

Philip Hewig

ADDRESS

246 Orleans

D 67394 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 E. Mount St., 10 WARD)

2-FULL NAME

Serman V. Pfaff

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1442 E. Mount St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

6 If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mary C. Pfaff

6 DATE OF BIRTH (month, day, and year) Oct 24, 1862

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 60 11 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Expressman

(b) General nature of industry, business, or establishment in which employed (or employer)

Himself

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Frederick Pfaff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

W. Spillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

Mary C. Pfaff 1442 E. Mount St.

15

SEP 8 - 1922

T. A. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug - 1, 1922, to Sept - 7, 1922.

that I last saw him alive on Sept 6, 1922.

and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Hypertension - nephroma -

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

Edema of Lungs

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes - Date of Aug 10 - 22

Was there an autopsy? no -

What test confirmed diagnosis? Operation

(Signed) E. Gill Hall, M. D.

Sept 7, 1922 (Address) 1667 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

BALTIMORE CEM

20 UNDERTAKER

Philip's Herwig

DATE OF BURIAL

Sept 9, 1922

ADDRESS

206 Orleans St

D 67395

HEALTH DEPARTMENT—CITY OF BALTIMORE 67395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 5th Ave ST., 19 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 221 5th Ave ST., 19 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds.

How long in U. S., if of foreign birth? 17 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

221 5th Ave ST., 19 WARD

SEP 8 1922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/22 19

17 HEREBY CERTIFY, That I attended deceased from 1922, to 1922, that I last saw him alive on 30 July 1922, and that death occurred, on the date stated above, at 6:45 p.m.

The CAUSE OF DEATH* was as follows:

Respiratory failure

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

9/8, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 67396

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1708 Lancaster ST. WARD 2)

2-FULL NAME

Maryanna Pasela

(a) RESIDENCE NO.

1708 Lancaster ST. WARD 2

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of

Jacob Pasela

6 DATE OF BIRTH (month, day, and year)

July 15 1885

7 AGE

37 Years

Months

1

Days

22

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Jacob Pasela
1708 Lancaster ST.

15

Filed 1922 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 1 1922 to Sept 6 1922 that I last saw him alive on Sept 5 1922and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart
Failure(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Rousey M. D.
Sept 8 22 Address 801 N. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether: Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy RosarySept 9 1922

20 UNDERTAKER

ADDRESS

John A. Weber 1803 Bank

Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67397

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 N. Howard ST. 11 WARD)2. FULL NAME Maria Reeder Key(a) RESIDENCE NO. 718 N Howard ST. 11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of none6 DATE OF BIRTH (month, day, and year) Unknown7 AGE 75 Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none(c) Name of employer none9 BIRTHPLACE (city or town) St Marys Co Md (State or country)10 NAME OF FATHER John Hall Key11 BIRTHPLACE OF FATHER (city or town) St Marys Co Md (State or country)12 MAIDEN NAME OF MOTHER Juliette Reeder13 BIRTHPLACE OF MOTHER (city or town) St Marys Co Md (State or country)

14

Informant (Address) Mrs Harriet Reeder
2525 Maryland Ave

SEP 8 - 1922

Registrar LL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 192217 HEREBY CERTIFY, That I attended deceased from July 1922 to Sept 7 1922 that I last saw her alive on Sept 7 1922 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
(left hemiplegia)
(duration) yrs. 2 1/2 mos. 0 ds.CONTRIBUTORY (Secondary) arterio sclerosis
gradual progress
(duration) yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Clinical findings(Signed) Dr. J. H. Key M. D.(Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mechanicville Co Md20 UNDERTAKER John F Denny

DATE OF BURIAL

Sept 9 1922ADDRESS 715 Light

Information should be carefully supplied. Cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67398

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

American Sugar Refinery,

Registered No. C.....

City of BALTIMORE: (No. Foot of Woodall St. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Lambert M. Jones.....

(Residence in Baltimore: No. 253 E. Hamburg St. St., yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, July 11th, 1900. (Month) (Day) (Year)

7-AGE, 22 yrs. 1 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Shipping clerk. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER, George W. Jones.

11-BIRTHPLACE OF FATHER, (State or Country), Somerset Co. Md.

12-MAIDEN NAME OF MOTHER, Annie J. Muir.

13-BIRTHPLACE OF MOTHER, (State or Country), Somerset Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Anna E. Jones. (wife)

(Address), 253 E. Hamburg St.

15- SEP 8 - 1922 1912 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 3rd, 1922. Body found hanging Sept. 6th, 1922. (Mouth) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signature) (Duration) yrs. mos. ds.

(Signed) (Coroner) (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Holy Cross A.C.C. 2nd Sept 8, 1922

20-UNDERTAKER, ADDRESS

John F. Denny 715 Light St

D 67399 HEALTH DEPARTMENT—CITY OF BALTIMORE 67399

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 443 E Fort Ave ST. 24 WARD)

2-FULL NAME

Laura J. Dill

(a) RESIDENCE. NO. 443 E Fort Ave ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benson F. Dill

6 DATE OF BIRTH (month, day, and year) Dec 8, 1873

7 AGE Years 48. Months 8 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W. Va.

10 NAME OF FATHER Jerome Tabler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Martinsburg W. Va.

12 MAIDEN NAME OF MOTHER Mary D. Dill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Martinsburg W. Va.

14

Informant (Address) Mrs. Lang 443 E Fort Ave

15 Filed 1922 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-6-1922

17

I HEREBY CERTIFY, That I attended deceased from 2-8-1922 to 9-6-1922 that I last saw him alive on 9-5-1922 and that death occurred, on the date stated above, at 2 a m. The CAUSE OF DEATH* was as follows:

Cancer.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) Harry Goldburg M. D.

(Address) 2210 Kentwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery Sept 8 1922

20 UNDERTAKER

Mrs. J. E. Evans 1438 N. E. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67400

D 67400

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 11 Maryland Ave

ST. 75 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1 Maryland Ave Westport

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Couple

6-DATE OF BIRTH,

June 26, 1922

7-AGE,

2 yrs. 2 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country), Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7, 1922

17- I HEREBY CERTIFY, That I attended deceased from

Sept 3, 1922, to Sept 5, 1922,

that I saw him alive on Sept 3, 1922,

and that death occurred, on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH* was as follows:

Illness colitis

(Duration) 2 yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

1922

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

former or present residence

19-PLACE OF BURIAL OR REMOVAL,

Biederhill Cemetery

DATE OF BURIAL,

Sept 9, 1922

20-UNDERTAKER

Joseph J. Jaffer

ADDRESS

1600 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation important. See instructions on back of certificate.

D 67401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67401

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 W. Lexington ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Infant of Louis and Martha Walter.

(a) RESIDENCE NO.

1931 W. LexingtonST., 20 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 7 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Louis Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Martha Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant

(Address)

Louis Walter1931 W. Lexington St.

SEP 8 - 1922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

, 19

, 19

that I last saw him alive on

Sept 7, 1922and that death occurred, on the date stated above at 12:15 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

James H. Cunningham M. D.

9/8, 1922

(Address)

1729 N. ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Louden Park Cem

DATE OF BURIAL

Sept 8 1922

20 UNDERTAKER

George L. Schwal

ADDRESS

2101 ...

D 67402 HEALTH DEPARTMENT—CITY OF BALTIMORE 67402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL. 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.,

WARD)

2-FULL NAME

Allen, Florence

(a) RESIDENCE NO.

233 N Ann St

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

William Allen

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

Washington D. C.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town; State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town; State or country)

Unknown

14

Informant -
(Address)

JOHNS HOPKINS HOSPITAL.

15

SEP 8 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 6/22 19

17

I HEREBY CERTIFY, That I attended deceased from

Sept 5-22, 1922, to Sept 6-22, 1922.

that I last saw him alive on Sept 6-22, 1922.

and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

E clampsia

(duration) yrs. mos. 2 hrs

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

W. C. Gray

M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

John W. Henderson

ADDRESS

1502 E. Monument

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 67403

CERTIFICATE OF DEATH

1290 67403

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1418 E Preston St, ST. 9th WARD)

2-FULL NAME Elizabeth B. Mühler

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1418 E. Preston St.; 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6 DATE OF BIRTH May 22nd, 1848 (Month) (Day) (Year)

7-AGE 74 yrs. 3 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) None 037

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER John Seidel

11 BIRTHPLACE OF FATHER Germany (State or country)

12 MAIDEN NAME OF MOTHER Christina Seidler

13 BIRTHPLACE OF MOTHER Germany (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herman Mühler

(Address) 1418 E. Preston St.

15

Filed 1922 191 St. Wehr REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 7, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to Sept. 7, 1922

that I saw h^e alive on " 6, 1922

and that death occurred, on the date stated above, at 3:40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(Duration) 2 yrs. mos. ds.

Contributory (SECONDARY) Uræmia (Duration) 3 mos. ds.

(Signed) George A. Hartman M. D.

Sept. 7, 1922 (Address) 2214 Mayfield Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

20. UNDERTAKER ADDRESS

James H. W. Son 1810 N. Royal Ave.

D 67404 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67404

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 Fort Ave

ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward Monroe Freeberger

(a) RESIDENCE. NO.

411 Fort Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 22, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

7

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Bernard F. Freeberger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Elizabeth L. Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Edw. Freeberger, 431 Fort Ave

15

Filed

SEP 8 - 1922

S. E. Welch

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 6, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 27, 1922, to Sept. 6, 1922,

that I last saw him alive on Sept. 6, 1922,

and that death occurred, on the date stated above, at 11:05 P. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration)

yrs.

mos.

9 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Wm. S. Seabury

M. D.

1922 (Address)

638 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Ceme.

Sept. 8, 1922

20 UNDERTAKER

ADDRESS

Margaret E. Lynne

1421 High St.

Physicians should be carefully supplied. All should be stated EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67405

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

WARD) 3

2-FULL NAME

Annie Hymer

(a) RESIDENCE NO.

1127 E. Lombard

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

life mos.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 23-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

— — 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Jacob Hymer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Fannie Gager

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

SEP 8 1922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 4 1922 to Sept 8 1922 that I last saw him alive on Sept 8 1922

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOYAL

DATE OF BURIAL

Baltimore City Cemetery 9-8-1922

20 UNDERTAKER

ADDRESS

Pack Lewis 1439 E. Balto

D 67406 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67406

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *861 S. Dallas* ST. *3* WARD)2. FULL NAME *Stanislaus Krupp*(a) RESIDENCE NO. *861 S. Dallas* ST. *3* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *9*mos. *6*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec-1-1921*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
9 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*
(State or country)10 NAME OF FATHER *Philip Krupp*11 BIRTHPLACE OF FATHER (city or town) *Poland*
(State or country)12 MAIDEN NAME OF MOTHER *Jenny Ferrus*13 BIRTHPLACE OF MOTHER (city or town) *Poland*
(State or country)14 Informant *Philip Krupp*
(Address) *861 S. Dallas St.*15 Filled *SEP 8 - 1922*, 19 *1922* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 7, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept 7, 1922* to *Sept 7, 1922*that I last saw him alive on *Sept 7, 1922*and that death occurred, on the date stated above, at *4* m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. *14* ds.(duration) yrs. mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Yes*

Was there an autopsy?

What test confirmed diagnosis? *History & Examination*(Signed) *W. B. Bullup*, M. D., 19 (Address) *2224 W. North Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St. Stanislaus*

DATE OF BURIAL

20 UNDERTAKER *W. J. Sadowski*

ADDRESS

805 S. Ave

Exact statement of Occurrence should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D-67407 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

173 D 67407

1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL, ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Dr. William S. Halsted

(a) RESIDENCE NO.

1201 Euter Place ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Caroline H. Halsted

6 DATE OF BIRTH (month, day, and year)

Sept. 23-1852

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

69

11

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Physician

(h) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

N. Y.

10 NAME OF FATHER

William M. Halsted

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

N. Y.

12 MAIDEN NAME OF MOTHER

Mary Haines

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

N. Y.

14

Informant
(Address)

JOHNS HOPKINS HOSPITAL.

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 7th 1922

17

I HEREBY CERTIFY, That I attended deceased from
Aug 24th, 1922, to Sept. 7th, 1922,
that I last saw him alive on Sept. 7th, 1922,
and that death occurred, on the date stated above, at 11 45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (right lung)
Bacterial pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Fall stone in common duct
Ert. jaundice (duration) yrs. 7 mos. ? ds.

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? yes Date of Sept Aug 25

Was there an autopsy? yes

What test confirmed diagnosis?

autopsy

(Signed) Mont R. Reed, M. D.

19 (Address) Cincinnati General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

London Paris

DATE OF BURIAL

9-9 1922

20 UNDERTAKER

Henry W. Jenkins, Sons Co
Cremated

ADDRESS

McMillan

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL ST., 7 WARD)

2-FULL NAME

Julia Gordon

(a) RESIDENCE NO.

(Usual place of abode)

10 Remond St., Va.

ST.

WARD

16 Rosemont Ave. Alexandria -

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 30 - 1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

4

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N. Y.

10 NAME OF FATHER

John B. Gordon

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Missouri

12 MAIDEN NAME OF MOTHER

Bertha O'Donoghue

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Buffalo N. Y.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

Robert F. Haffner,

19

Registrar

Burial Permitted Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 8 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 11, 1922, to Sept. 8, 1922,

that I last saw her alive on Sept 8, 1922,

and that death occurred, on the date stated above, at 1:45 A.M.

The CAUSE OF DEATH* was as follows:

Meningeal inflammation cause?

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? no

Did an operation precede death? yes Date of Sept. 2

Was there an autopsy? yes - partial

What test confirmed diagnosis? operation

(Signed) J. L. Reichert M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Buffalo N. Y. Sept 8 1922

20 UNDERTAKER

ADDRESS

John D. Mitchell 201 W. Fayette

CAUTION should be carefully supplied. AGE should be stated EXACTLY. PRESENT CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

8-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67409

D 67409

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 h Chapel ST.; 8 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1840 h Chapel St.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH,

January 20, 1918 (Month) (Day) (Year)

7-AGE,

4 yrs., 7 mos., 19 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Baltimore, Md

10-NAME OF FATHER,

Louis Ruland

11-BIRTHPLACE OF FATHER (State or Country).

Bedburg, Germany

12-MAIDEN NAME OF MOTHER

Lydia Ruland

13-BIRTHPLACE OF MOTHER (State or Country).

New York City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Louis Ruland

(Address) 1840 h Chapel St.

15-

SEP 8 - 1922

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 8, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

September 4, 1922 to September 8, 1922 that I saw her alive on September 7, 1922, and that death occurred, on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

CONTRIBUTORY (Secondary)

(Signed) E. H. Thompson M. D.

(Address) 1027 North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore Cem

DATE OF BURIAL,

1922

20-UNDERTAKER

B. L. Cunningham

ADDRESS

Lafayette Ave

D 67410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67410

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *116 W. 28th* ST., *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *116 W. 28th* ST., *12* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Five* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female White**Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 26th 1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*65*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Clarence K. Younger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Margaret Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Margaret Blountly 1861 Edmonstone ave

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Aug 19th 1922 to Sept 7th 1922*that I last saw her alive on *Sept 7th 1922*and that death occurred, on the date stated above, at *11.30 a.m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Gremia

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *residence*Did an operation precede death? *yes* Date of *8/21/22*Was there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *W. J. Coleman* M. D.. 19 (Address) *Md Genl Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St Paul Kent Co Md**Sept 10 1922*

20 UNDERTAKER

ADDRESS

Chester with Son Chestnut Ave

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

SEP 9-1922

Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67411F

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67411F

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (NO. *29th & Hello Road* ST. *13* WARD)
2-FULL NAME *John Sisk*
(Residence in Baltimore No. *1430 Mill race Road* St. *7* yrs. mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *M.* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Single*
6-DATE OF BIRTH *Unknown*, 1 (Month) (Day) (Year)
7-AGE, *32* yrs. mos. ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Solar*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), *Id.*
10-NAME OF FATHER, *Unknown*
11-BIRTHPLACE OF FATHER (State or Country), *"*
12-MAIDEN NAME OF MOTHER *"*
13-BIRTHPLACE OF MOTHER (State or Country), *"*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Laurel W. Sisk*
(Address) *1840 Light St.*

15-
Filed *Robert P. Harrison,* 101. Registrar.
22 Serial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Aug 22*, 191*2* (Month) (Day) (Year)
17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy, or inquiry thereon and from the evidence obtained by said inquest, autopsy, or inquiry, and that said deceased came to death topsy or inquiry on the day stated above.
The CAUSE OF DEATH was as follows:
Accidental Drowning
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.
(Signed) *Frank Morrison* M. D. (Coroner.)
191*2* (Address) *7632 Belmont*
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, *Laurel Ind* DATE OF BURIAL, *Sep 9*, 191*2*
20-UNDERTAKER *Chenoweth Son Chestnut Ave* ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67412

CERTIFICATE OF DEATH.

REGISTERED NO. C

D 67412

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 447 Biddle ST. 11 WARD)

2-FULL NAME

(Residence in Baltimore: No. 247 Biddle St.; 1 yrs., 6 mos., 6 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Widow

6-DATE OF BIRTH,

1858, 1, 1
(Month) (Day) (Year)

7-AGE,

64 yrs., 6 mos., 6 ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...

(Address)...

15-

Filed

Robert P. Harrison,

191

Registrar.

8-1922

Burial Permit No. 1000

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 7th, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 4th 1922 to Sept 7th 1922, that I saw him alive on Sept 6th 1922, and that death occurred, on the date stated above at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated
Intestine

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

9/8, 1922 (Address) 924 and 2

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laural Lane

Sept 9, 1922

20-UNDERTAKER

ADDRESS

Daniel Egan

894

D 67413

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67413

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin D. Hospital* ST. *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. *823 W. Barre* ST. *WARD*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of *Celia Bachman*6 DATE OF BIRTH (month, day, and year) *Jan. 1866*7 AGE *56* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Export job*(b) General nature of industry, business, or establishment in which employed (or employer) *Salesman*

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany*
(State or country)10 NAME OF FATHER *Moses Bachman*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Katrine Hunsback*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*

14

Informant *Lepold Bachman*
(Address) *54 Pratt St.*

15

Filed *1922*

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/7/1922*

17

I HEREBY CERTIFY, That I attended deceased from

9-1-, 19*22*, to *7-7-*, 19*22*,that I last saw him alive on *7-7-*, 19*22*and that death occurred, on the date stated above, at *706* A. M.

The CAUSE OF DEATH* was as follows:

Gangrene of amputated
Left femur(duration) yrs. mos. ds. *6*

CONTRIBUTORY

(Secondary)

arteriosclerosis (duration) yrs. mos. ds. *2*18 Where was disease contracted
if not at place of death?Did an operation precede death? *yes* Date ofWas there an autopsy? *no*What test confirmed diagnosis *Sp. & Hist. finding*(Signed) *Newton J. Park*, M. D.19/1922 (Address) *Franklin D. Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Hebrew Burial Society
J. Ahrens & Co. *1611 Madison*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67414

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3614 Cottage Ave. ST. 15 WARD)

2-FULL NAME Margaret E. Morgan

(a) RESIDENCE. No. 3614 Cottage Ave. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 12-1892

7 AGE Years 30 Months 7 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Louis Markmeister

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Amelia Bichy

13 BIRTHPLACE OF MOTHER (city or town) Balt. Md. (State or country)

14 Informant Mrs Amelia Markmeister (Address) 3614 Cottage Ave.

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7 1922

17 I HEREBY CERTIFY, That I attended deceased from 4/12/22 1922, to 9/7/22 1922, that I last saw him alive on 9/7 1922, and that death occurred, on the date stated above, at 5 P. m. The CAUSE OF DEATH* was as follows:

Typhoid fever.

CONTRIBUTORY (Secondary)

Exhaustion (duration) 1 1/2 yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Blood Exam.

(Signed) Harry Goldberger M. D.

9/8 1922 (Address) 2210 Emden Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery Sept 9 1922

20 UNDERTAKER STEWART & MOVEN COMPANY

(WILLIAM F. WOODEN, Successor)

ADDRESS 108 W. NORTH AVE.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67415

D 67415

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 Belt ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Jarner(a) RESIDENCE. No. 1842 Belt ST. 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) Jun 27/19047 AGE Years 18 Months 2 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER John A. Jarner11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.12 MAIDEN NAME OF MOTHER Hattie E. Granger13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.14 Informant John A. Jarner (Address) 1842 Belt St.15 Filed Robert F. Hallahan Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 19 2217 I HEREBY CERTIFY, That I attended deceased from Jun 10, 1922 to Sept 6, 1922 that I last saw him alive on Sept 5, 1922and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Distention of Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? ChemicallySigned R. H. Campbell M. D. (Address) 1644 Hancock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cem. DATE OF BURIAL Sept 9, 1922

20 UNDERTAKER

Margaret H. Flannery ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EP 8-1922

Burial Permit Blank.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67416

CERTIFICATE OF DEATH.

114 D 67416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2643 W. North Ave. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Andrew Jackson Jr.

(a) RESIDENCE. NO.

2643 W. North Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 7th 1920

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.212

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None9 BIRTHPLACE (city or town)
(State or country)Balto. Ind.

10 NAME OF FATHER

Andrew Jackson11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto. Ind.

12 MAIDEN NAME OF MOTHER

Virginia Pindell13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto. Ind.

14

Informant

(Address)

Andrew Jackson Jr.
2643 W. North Ave.

15

Filed

19

Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 8th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 4th 1922, to Sept. 8th 1922that I last saw him alive on Sept. 8th 1922and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) George E. Cross, M. D., 19 (Address) 2409 Ind. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

At Oak LawnSept. 11 1922

20 UNDERTAKER

ADDRESS

Wm CookWm G. Mc

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

1922

Burial Permit Clerk

D 67417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67417

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 W 28th ST. 17th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE, No. 401 W 28th ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds.

How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR & RACE

5 Single, Married, Widowed, or Divorced (write the word)

6 If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 6 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 19 17, to Sept 6, 1922

That I last saw her alive on Sept 6, 1922

and that death occurred, on the date stated above, at 1235 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Renal disease of heart
mitral dilation.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

dyslipidemia (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Norment, M. D.

9. 6. 1922 (Address) 3345 Chelton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

9/9 1922

20 UNDERTAKER

ADDRESS

Wm Cook

502 E. N. Ave

Exact statement of OCCASION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

8-1922

Burial Permit No. 1000

Sister M. Armella Gemmer ✓
HEALTH DEPARTMENT - CITY OF BALTIMORE

67418

CERTIFICATE OF DEATH.

57 D 67418

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph's Hospital* ST., WARD)

2-FULL NAME

(a) RESIDENCE NO. *Sister M. Armella Gemmer*

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. — mos. — ds.How long in U. S., if of foreign birth? *40* yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Not Known 1854*

7 AGE

Years

Months

Days

68

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Religious Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *John Gemmer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Not Known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Not Known*14 Informant (Address) *Records at St. Joseph's Hospital*

15

SEP 9 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 8 1922*17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 1922, to Sept 8, 1922, that I last saw *her* alive on Sept 8, 1922, and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

*myocardial infarction*CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *Diabetes Mellitus*18 Where was disease contracted if not at place of death? *No*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *J. Schenck* M. D.(Address) *St. Joseph's Hosp.*

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Holy Redeemer Cemetery**Sept 11 1922**Henry Horch Son**1301 E. Eager St.*

Exact statement of OCCURRENCE should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67419

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

August 30 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Daniel Belluzzi

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Rosary Presti

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Daniel Belluzzi
144 S Robison

15

Filed

19

SEP 9 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sep 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 29 1922, to Sept 8 1922, that I last saw him alive on Sept 7 1922.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Defective valves of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY

Defective valves of the heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. S. Crippage, M. D.

(Address) 2303 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Vincent
Wendell Dippel & Son

378 Mount

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

ST. 23 WARD

CITY OF BALTIMORE: (NO.)

2. FULL NAME

Alexander Riga

(a) RESIDENCE NO.

1012 Hanover St

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Child

6 DATE OF BIRTH (month, day, and year)

Nov 9 - 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Pete Riga

11 BIRTHPLACE OF FATHER (city or town)

Poland

(State or country)

12 MAIDEN NAME OF MOTHER

Sophie

13 BIRTHPLACE OF MOTHER (city or town)

Poland

(State or country)

PARENTS

14 Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

Filed

SEP 9 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1922, to Sept 8, 1922, that I last saw him alive on Sept 8, 1922, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Tuberculosis - Septicemia

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 3 mos. 8 ds.

Pneumonia - Tuberculosis - Septicemia

(duration) 0 yrs. 0 mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 0

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed)

H. F. Weech M. D.

19 (Address)

Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer

Sep. 9th 1922

20 UNDERTAKER

John Grebliauckas

ADDRESS

425 S Paca St

D 67422

HEALTH DEPARTMENT—CITY OF BALTIMORE

67422

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1533 Jefferson, ST., 6 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1533 Jefferson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Reid6 DATE OF BIRTH (month, day, and year) June 16-18947 AGE Years 28 Months 2 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pickensville, Va.10 NAME OF FATHER Alvin Ross11 BIRTHPLACE OF FATHER (city or town) (State or country) va.12 MAIDEN NAME OF MOTHER Auelia White13 BIRTHPLACE OF MOTHER (city or town) (State or country) va.

14

Informant (Address) 1533 Jefferson St.

SEP 9 - 1922

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 192217 I HEREBY CERTIFY, That I attended deceased from July 31, 1922, to Sept. 6, 1922, that I last saw her alive on Sept. 6, 1922, and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-intestinal CatarrhCONTRIBUTORY (Secondary) Cardiac cathexis (duration) yrs. 1 mos. 6 ds.18 Where was disease contracted if not at place of death? Balto. Md.Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) John C. Robinson, M.D.(Address) 1520 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL DATE OF BURIAL

Asbury Cemetery Sept. 7, 1922

20 UNDERTAKER ADDRESS

Christie Johnson 467 N. 1st St.

Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67423 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp 5* St. *5* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Regina Flemings*

(Residence in Baltimore: No. *319 Forest* St.; yrs. *2* mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *Colored* 5-Single, Married, Widowed, Divorced, (Write the word.) *Single*

6-DATE OF BIRTH, *May 4*, 19*22* (Month) (Day) (Year)

7-AGE, *4* yrs. *3* mos.ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *None* (b) General nature of industry, business, or establishment in which employed (or employer) *—*

9-BIRTHPLACE, (State or Country), *Philadelphia Pa.*

10-NAME OF FATHER, *William Flemings*

11-BIRTHPLACE OF FATHER, (State or Country), *North Carolina*

12-MAIDEN NAME OF MOTHER, *Emma Standford*

13-BIRTHPLACE OF MOTHER, (State or Country), *Philadelphia Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Emma Flemings*

(Address) *319 Forest Street*

SEP 9 - 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *September 7*, 19*22* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows: *Shock from fall, Fall from bed.*

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) (Duration)yrs.mos.ds.

(Signed) *J. S. Brown* (Coroner) *9-9-1922* (Address) *508 E. Mount*

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death,yrs.mos.ds. In the State,yrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Albany Cem* DATE OF BURIAL, *Sept 10*, 19*22*

20-UNDERTAKER, *Christ A. Johnson* ADDRESS, *446 N. Carolina*

nothing. No autopsy made.
No further discussed.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyemia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicemia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67424

67424

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Division ST., 17 WARD)2. FULL NAME Margaret Wallace(a) RESIDENCE NO. 1215 Division ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed or divorced HUSBAND of James A. Wallace (or) WIFE of6 DATE OF BIRTH (month, day, and year) 18767 AGE 46 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER James Delaney11 BIRTHPLACE OF FATHER (city or town) (State or country) City12 MAIDEN NAME OF MOTHER Barber Copps13 BIRTHPLACE OF MOTHER (city or town) (State or country) City14 Informant James A. Wallace (Address) 1215 Division

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 12, 1922, to Sept. 7, 1922.that I last saw him alive on Sept. 7, 1922.and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Bright Disease(duration) 1 yrs. mos. ds.CONTRIBUTORY Arterio-sclerosis (Secondary)(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Whalley, M. D., 19 (Address) 1230 S. 1st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

CathedralSept 11 1922

20 UNDERTAKER

ADDRESS

Chas. E. Smith, 1344 N. Ave.

SEP 9 - 1922

Filed

Registrar

Physicians should state EXACTLY. Exact statements of OCCUPATION should be stated EXACTLY. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67425 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67425

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1509 N. Calhoun St. 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1509 N. Calhoun Jr. St.; yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

57 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence E. Jones

(Address) 1465 N. Carey St.

SEP 9 - 1922

Filed

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Heenan, M. D.

(Coroner)

Sept. 7, 1922 (Address) 210 N. Carey St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

1465 N. Carey St. Sept 9, 1922

20-UNDERTAKER, ADDRESS

Edward Pungel 1463 N. Carey

D 67426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Thomas J. Airey.....

15

(Residence in Baltimore: No. 1330 S. Charles St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, White, 5-Single, Married, Widowed, or Divorced, Married (Write the word.)6-DATE OF BIRTH, April 29th, 1856, 1. (Month) (Day) (Year)7-AGE, 65 yrs. 3 mos. 8 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Dorchester Co. Md.10-NAME OF FATHER, Do not know.11-BIRTHPLACE OF FATHER, (State or Country), Do not know.12-MAIDEN NAME OF MOTHER, Do not know.13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary F. Airey. (wife)(Address) 1330 S. Charles St.

15.

Filed

SEP 9 - 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 6th, 1922, 192. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart
Congestion of the Lungs.
Heat Prostration.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signed) Chas. M. Reinhardt M. D. (Coroner.)Sept. 8th 1922 (Address) 1015 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Foot of Warren Ave. Sept. 6th, 1922.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western CemeterySept 9, 1922

20-UNDERTAKER,

ADDRESS

John T. Denny715 Light St

CAUTION: This is a preliminary statement of death. It is not to be used for legal purposes. It is to be used only for the purpose of recording the death. It is to be used only for the purpose of recording the death. It is to be used only for the purpose of recording the death.

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 67427**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 Quick Ave ST.: 76 WARD)

2-FULL NAME

Morty M. Tyler

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

25 Quick Ave

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 2nd 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 3 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

William E Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Carsfield Pa

12 MAIDEN NAME OF MOTHER

Emma Longhans

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria Hungary

14

Informant (Address)

William E Tyler
25 Quick Ave

SEP 8 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 8 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1922, to Sept 8, 1922, that I last saw her alive on Sept 8, 1922.

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

Broncho pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death?

at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John J. Fick, M. D.
936 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Parkwood Cemetery

DATE OF BURIAL

Sept 10th 1922

20 UNDERTAKER

George Schilling & Sons

ADDRESS

126 E Monument

D 67428

HEALTH DEPARTMENT—CITY OF BALTIMORE 67428

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 N. Henry

ST.,

WARD) 19

2. FULL NAME

Anthony A. Collins

(a) RESIDENCE NO.

1406 N. Henry

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 1/2 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15 SEP 9 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

9/6, 1922 to 9/7/22, 1922

that I last saw him alive on 9/7/22, 1922

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard Henry, M. D.

19 22 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Peters Bern

Sept 9th 1922

20 UNDERTAKER

A. Jones

ADDRESS

1112 Gilmor

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67429

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2820 Frederick Ave* ST. *70* WARD)

2. FULL NAME

(a) RESIDENCE NO. *2820 Frederick Ave*

(Usual place of abode)

Length of residence in city or town where death occurred *18* yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

*Female White Widowed.*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles Duffindal*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *62. 2 1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

PARENTS

14 Informant (Address)

SEP 9 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 6 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Aug 17 1922 to Sept 6 1922*that I last saw him alive on *Sept 6 1922*and that death occurred, on the date stated above, at *8 P* m.

The CAUSE OF DEATH* was as follows:

Varicella of
utero
(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *Physical findings*(Signed) *W. A. Hall*, M. D.9/5, 1922 (Address) *Longton*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL *Green Cathedral*

20 UNDERTAKER

*Geo. L. Schwab**1011 North Ave*

DATE OF BURIAL

Sept 11 1922

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 67430 HEALTH DEPARTMENT—CITY OF BALTIMORE

67430

CERTIFICATE OF DEATH

1-PLACE OF DEATH Vol. of American Hospital
CITY OF BALTIMORE: (No. 418 W. Lexington ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas. Edward Hawk

(a) RESIDENCE. No. ST. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 9-8-22
7 AGE Years Months Days If LESS than 1 day, hrs. or min. 30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer.9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Edw. W. Hawk

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country)

12 MAIDEN NAME OF MOTHER Ethel M. Reed

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)14 Informant Edw. W. Hawk
(Address) 406 St. Paul

15 Filled 19 SEP 9-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from 9-8-22, 19, to 9-8-22, 19, that I last saw him alive on 9-8-22, 19, and that death occurred, on the date stated above, at 7:20 P. m.
The CAUSE OF DEATH* was as follows:Premature Birth
(6 months chd)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert J. Courcy, M. D.

19 (Address) Vol. of A. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHN HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

Crematorium

SEP 9-1922

D 6743E

HEALTH DEPARTMENT—CITY OF BALTIMORE 6743E

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rebecca Hayes

(a) RESIDENCE. No.

ST.

WARD.

New Windsor, Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *6* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Luther Hayes

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*55*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*New Windsor
Maryland*

10 NAME OF FATHER

Murdock Hayes

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant
(Address)*deceased*

SEP 9 - 1922

H. W. M.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *9-9-22*

17

I HEREBY CERTIFY, That I attended deceased from

9/6, 19*22*, to *9/9*, 19*22*,that I last saw him alive on *Aug. 9*, 19*22*,and that death occurred, on the date stated above, at *4:59 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *Yes* Date of *9/7/22*Was there an autopsy? *no*What test confirmed diagnosis? *operation*(Signed) *Anthony V. Buckner, M. D.*, 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. John's Cemetery**Sept. 10, 1922*

20 UNDERTAKER

ADDRESS

*C. M. Smith**31 Infield*

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Had 1 gall stone.
Not Luetic.

D. 67432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 67432

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Madison ST. 14 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1704 Madison ST. WARD.

(Usual place of residence)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) Married

6 If married, widowed, or divorced (or) WIFE of McKee

6 DATE OF BIRTH (month, day, and year)

7 AGE 37 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant Mary Perry (Address) 1704 E. Madison St.

SEP 9 - 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 7 1922

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1922, to Sep 7, 1922, that I last saw her alive on Sep 6, 1922, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Chl. Endocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wael. H. White 9/8, 1922 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Int Aurlun Cemetery Sept 10 1922

20 UNDERTAKER

Mrs Robert A Elliott Ashland

D 67433 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67433

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 139 St. Preston

ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and put out No. 18.)

2-FULL NAME

Margaret Fowler

(Residence in Baltimore: No. 139 St. Preston

St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH,

Jan 30, 1922
(Month) (Day) (Year)

7-AGE,

7 yrs. 8 mos. 8 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

James E. Fowler

11-BIRTHPLACE OF FATHER (State or Country),

Asheville N.C.

12-MAIDEN NAME OF MOTHER

Maggie Green

13-BIRTHPLACE OF MOTHER (State or Country),

Columbia S.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

James E. Fowler

(Address)

139 St. Preston St.

15-

SEP 9 - 1922

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 8, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 8 to Sept 8, 1922.

that I saw her alive on Sept 8, 1922,

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH was as follows:

Bronchitis pneumonia

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

9/8, 1922 (Address) 924 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cemetery

DATE OF BURIAL,

Sept 9, 1922

20-UNDERTAKER

Mrs. W. Johnson

ADDRESS

1234 Ething St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in very important. See instructions on back of certificate.

D 67434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 512 St. Mary's St. 17

2-FULL NAME

Thos. Powell

(Residence in Baltimore: No. 512 St. Mary's St.

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

Sept 7, 1922

7-AGE,

yrs. 1 mos. 1 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Hennessy, M. D.

(Address) 2802 Eastman Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D-57435 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67435

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL, ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Anita Stanley

(a) RESIDENCE No. 1008 Carrollton Ave City

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Single.

5a If married, widowed, or divorced
Lillian Stanley (mother),

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1921.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
10 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Le Roy Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Lillian Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 SEP 9-1922

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1922

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1922, to Sept 6, 1922, that I last saw her alive on Sept 6, 1922, and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery).

(duration) yrs. 2 mos. 12 ds.

CONTRIBUTORY (Secondary)

Malnutrition.

(duration) yrs. 2 mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

1922

UNDERTAKER

ADDRESS

St. Andrew

1211

maison should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67436

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.:

WARD.

Length of residence in city or town where death occurred

60 yrs.

11 mos.

14 ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 8, 1922 to Sept 8, 1922

that I last saw her alive on Sept 8, 1922

and that death occurred, on the date stated above, at 4:40 P.m.

The CAUSE OF DEATH* was as follows:

Cancer (Face)

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Auscultation of heart

(Signed) Geo. L. Zimmermann, M. D.

19 (Address) 2858 Hayford Rd

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem

9/11/22

20 UNDERTAKER

E. J. Manning 1001 Wash St

ADDRESS

Lafayette Ave

tion should be carefully supervised. All should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10 1922

67437
D 67437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67437
D 67437

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 Rutland Ave ST., 8 WARD)

2-FULL NAME Mary A. Coulter

(a) RESIDENCE NO. 1600 Rutland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 10 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced. (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Wm J. Coulter

6 DATE OF BIRTH (month, day, and year) October 29, 1869

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

52

10

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John McGuire

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ellen Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Wm J. Coulter

1600 Rutland Ave

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 1922

17

I HEREBY CERTIFY, That I attended deceased from June 24th 1922, to Sept 7th 1922.

that I last saw her alive on Sept 7th 10 AM, 1922.

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) one 2 yrs. mos. da.

CONTRIBUTORY (Secondary)

Anemic Poisoning

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Clinical Symptoms Test

(Signed)

Wilmer Brimton

M. D.

19

(Address)

1 W. Cor. Calvert & Frederick Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

DATE OF BURIAL

9/11 1922

20 UNDERTAKER

George J. Ruth

ADDRESS

1735 Harford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

P 10 1922

Burial Permit Clerk

D 67438

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67438

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 N. Hayward ST., 27 WARD)

2. FULL NAME

(a) RESIDENCE NO. 836 N. Hayward ST.,(Usual place of abode)
Length of residence in city or town where death occurred 57 yrs. — mos. — ds.

WARD

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? — yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, ... hrs.
or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant
(Address)

15

Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 19 2217 I HEREBY CERTIFY, That I attended deceased from
July 6, 19 22, to Sept 8, 19 22.
that I last saw him alive on Sept. 8, 19 22,
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:Carcinoma of Right BreastCONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen J. Steelman M. D.
, 19 (Address) 1227 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

101922

100-00

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

17

ST. WARD

(If non-resident give city or town and State)

ds. How long in U. S. If of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from
Sept. 2, 1922 to Sept. 7, 1922
that I last saw him alive on Sept. 7, 1922

and that death occurred on the date stated above, at 7:30

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

.....

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acidoxia

..... (duration) yrs. mos. 5 ds.

18 Where was disease contracted
if not at place of death?.....XXXX

Did an operation precede death? No Date of XX

Was there an autopsy? No

What test confirmed diagnosis? XXX

(Signed) Al. White, M. D.

19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
--------------------------------------	----------------

MOVAL
Sausal Cemetery Sept 10, 192

MAINTENANCE OF RECORDS

D 67440

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67440

CERTIFICATE OF DEATH.

1. PLACE OF DEATH 936 E. Reddle St
CITY OF BALTIMORE: (No. 936 E Reddle ST., 10 WARD)

2. FULL NAME Ann Rebecca Brady

(a) RESIDENCE NO. 936 E Reddle ST., 10 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced, widow of Robert H Brady

6 DATE OF BIRTH (month, day, and year) Sept 11 1827

7 AGE Years 94 Months 11 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cecil Co. Md.
(State or country)

10 NAME OF FATHER Sylvester Nugent

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Aldridge

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Mrs. Geller (daughter)
(Address) 936 E Reddle St

15 10 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1922

17 I HEREBY CERTIFY That I attended deceased from Sept 3, 1922, to Sept 8, 1922, that I last saw her alive on Sept 8, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 5 ds.
CONTRIBUTORY Cerebral hemorrhage
(Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted Place of death
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal tests

(Signed) C. E. McDonald, M. D.

19 1922 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

Baltimore Ann. Sept 11 1922

20 UNDERTAKER ADDRESS

Henry Lutz 203 North Broadway

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67441

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1127 E. Fayette St. 5 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1127 E. Fayette St.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and all out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH

Unknown, 1854 (Month) (Day) (Year)

7-AGE,

68 yrs. mos. ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Tailor

9-BIRTHPLACE.

(State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER

(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

William Bressler

(Address)

126 St. Schroeder St.

15-

Filed,

Robert P. Harrison,

191

Registrar.

Burial Place

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

9-9th, 1922 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Latv. As. heart

Some time (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

1912 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Hehren Int. Cemetery

DATE OF BURIAL,

9-10, 1922

20-UNDERTAKER

Jack Lewis

ADDRESS

1439 E. Balt. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67442

D 67442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., If of foreign birth?

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

September 9, 1922, to September 9, 1922.

that I last saw him alive on September 9, 1922.

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) 5 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Joches M. D.

9/9, 1922 Address) The Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67443

CERTIFICATE OF DEATH.

117 D 67443

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Monument

ST.: 12 WARD)

2-FULL NAME

Mr. Raymond Davidov

(a) RESIDENCE. NO.

2241 Barclay St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

17

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

17

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1904

7 AGE

Years

Months

Days

IF LESS than
1 day, hrs.
or min.

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Grocery clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

Harry Davidov

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

Hosp

15

Filed

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to Sept 8, 1922

that I last saw him alive on Sept 8, 1922

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Peritonitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY
(Secondary)appendix abscess with
peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? yes Date of Sept 1

Was there an autopsy? no

What test confirmed diagnosis?

Physical Exam.

(Signed)

Ernest Ballantyne, M. D.

1/8, 1922

Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Mt Carmel

DATE OF BURIAL

9/10 1922

20 UNDERTAKER

Jack Lewis 1439 E. Baltimore

ADDRESS

Match should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL

ST.,

WARD) 3

2-FULL NAME

Rose Hymer

(a) RESIDENCE NO.

1127 E. Lombard

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

16 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 23 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, MD

10 NAME OF FATHER

Jacob Hymer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Fannie Hymer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 8 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

, 19

to Sept 8 - 1922

that I last saw him alive on

Sept 8 - 1922

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration)

yrs.

mos

Sfed.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Horton Casparis, M. D.

, 19

(Address)

Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Workmen Circle

DATE OF BURIAL

9/10 1922

20 UNDERTAKER

Jack Lewis 1439 E. Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Partial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67445

CERTIFICATE OF DEATH.

74 D 67445

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 Mc Cullagh St. 14 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1716 Mc Cullagh ST. WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Unmarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Blake

6 DATE OF BIRTH (month, day, and year) 9-12-1859

7 AGE Years 62 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Edward Blake

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Wicksford

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. Sarah Ditchell (Address) 1716 Mc Cullagh St.

15 Filed 1922 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-22

17 I HEREBY CERTIFY, That I attended deceased from 9-22-22, 19 to 9-9-22, 19

that I last saw him live on " 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

apoplexy

CONTRIBUTORY (Secondary) Arterio-sclerosis (duration) yrs. 5 mos. ds.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. W. Cades, M. D.

, 19 (Address) 524 V. Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Harriet Wright, 36 Mary

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67446

CERTIFICATE OF DEATH.

3D 67446

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *621 S. Bethel* ST., *2* WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, that I attended deceased from *Sept 7*, 19*22* to *Sept 9*, 19*22*, that I last saw him alive on *Sept 8*, 19*22*, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

BURYAL

DATE OF BURIAL

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10-1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67447

CERTIFICATE OF DEATH.

161-981
D 67447

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5210 Deamore Ave ST 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Brown(a) RESIDENCE. NO. 5210 Deamore Ave ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Several months yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Cal 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 9/9/227 AGE Years Months Days If LESS than 1 day, hrs. or min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Ind
(State or country)10 NAME OF FATHER Robt Brown11 BIRTHPLACE OF FATHER (city or town) Ind
(State or country)12 MAIDEN NAME OF MOTHER Irene Burt13 BIRTHPLACE OF MOTHER (city or town) Ind
(State or country)14 Informant Robt C Brown
(Address) 3210 Deamore15 Filed 19 P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/9/2217 I HEREBY CERTIFY, That I attended deceased from 9/9/22, 1922, to 9/9/22, 1922, that I last saw him in bed on 9/9/22, 1922, and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(duration) Instant yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Home
if not at place of death?Did an operation precede death? n Date ofWas there an autopsy? nWhat test confirmed diagnosis? Clinical(Signed) Walter M. D.(Address) Culver

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Heumann DATE OF BURIAL Sept 1020 UNDERTAKER Heumann ADDRESS early 1922

JAMES H. DENNIS

1303 PRESTMAN ST

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10 1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67448

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH *St Vincent Infirmary*CITY OF BALTIMORE: (No. *1401* - Division *St* ST. *14* WARD)2. FULL NAME *Concetta Speltore*

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD *Cumberland Md.*

Length of residence in city or town where death occurred

yrs.

mos.

7

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 10, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**29*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Cumberland Md*10 NAME OF FATHER *Vincenzo Speltore*

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

*Italy*12 MAIDEN NAME OF MOTHER *Concetta Bottolo*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Italy

14

Informant

(Address)

St Vincent Infirmary

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*Sept. 8*19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 8, 1922, to Sept. 8, 1922.
that I last saw him alive on *Sept. 8, 1922*and that death occurred, on the date stated above, at *12* m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Gas. R. Goldberger

M. D.

19

(Address)

2735 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

P 10 1922

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67449

CERTIFICATE OF DEATH.

D 67449

1-PLACE OF DEATH

St. Vincent's Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1401 Division

ST. 14

WARD)

2-FULL NAME

Alex. McCauley

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs. 1

mos. 5

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 3, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Mary Mc Cauley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

D.C.

14

Informant (Address)

St. Vincent's Infirmary 1401 Division St.

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 3, 1922, to Sept 8, 1922, that I last saw him alive on Sept 8, 1922,

and that death occurred, on the date stated above, at 3 P.m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. R. Goldborough, M. D.

19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAR

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Cathedral Cemetery
Martin Tucker Son 1827 W North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

P 10 1922

Burial Permit Clerk.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No gastro enteritis.
Malnutrition due
to congenital debility

Spec.—1-10-21—M&T—1500 Bks.

D 67450

HEALTH DEPARTMENT—CITY OF BALTIMORE

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 W Franklin ST., 20 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1903 W Franklin ST.,

(Usual place of abode)
Length of residence in city or town where death occurred 65 yrs.

WARD

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male White Widower

5a. If married, widowed, or divorced

HUSBAND of

Caroline Neubauer Aug 13 1857

6 DATE OF BIRTH (month, day, and year)

7 AGE

65

Months

1

Days

7

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Casper Neubauer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

Margaret Beecher (Daughter) 1903 W Franklin St.

15

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1922

17 I HEREBY CERTIFY, that I attended deceased from April 1, 1922, to Sept. 8, 1922.

that I last saw him alive on Sept 8, 1922, at 12:40 P. M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
Apoplexy.

CONTRIBUTORY (Secondary)

Diabetes Mellitus (duration) yrs. mos. 2.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis

(Signed) M. S. Spillinger, M.D. Address 682 Columbus Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

20 UNDERTAKER

Mr. Chas. A. G. Rohde 600 Marlinton Ave.

DATE OF BURIAL

9-11-22

ADDRESS

10-1922

Serial Permit 6162

D 67451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Anna M. Donaldson

6 DATE OF BIRTH (month, day, and year)

June 29-1855

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

67

2

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto.
Md.

10 NAME OF FATHER

Robt. M. Donaldson

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Eliza J. Stone

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Md.

14

Informant,
(Address)Anna M. Donaldson
1035 N. Mulberry St.

15

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 6 1922, to Sept 8 1922

that I last saw him alive on Sept 8 1922

and that death occurred, on the date stated above, at 3:40 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
If not at place of death?

at home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinically

(Signed)

J. A. Wilkerson M. D.

19

(Address)

Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Olivet Cemetery

Aug 11 1922

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

EP 10 1922

Burial Permit Clerk.

(Catherine Wagner)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67452

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. ST., WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs.

3 mos.

18 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

(or) WIFE of

Frederick

6 DATE OF BIRTH (month, day, and year)

May 26 1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40

3

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md

10 NAME OF FATHER

Conrad Schwalbe

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Hanna Donawick

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14 Informant (Address)

Frederick Leppner
412 Marshall St.

15

19

Regist.

Regist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1922

17 HEREBY CERTIFY, That I attended deceased from Sept. 6, 1922, to Sept. 8, 1922, that I last saw her alive on September 8, 1922, and that death occurred, on the date stated above, at 9:15 p. m.

The CAUSE OF DEATH* was as follows:

Intestinal toxemia
following intestinal
obstruction

CONTRIBUTORY (Secondary) Adhesion about Small Intestine (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 9/7/22

Was there an autopsy? No

What test confirmed diagnosis? P. S. S. & Operation

(Signed) J. V. Sczerbicki, M. D.

(Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

MOVING Cedar Hill Cem. 19

20 UNDERTAKER ADDRESS

Maryann Flynn 1422 Light

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

10 1922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Samuel Keene)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67453

CERTIFICATE OF DEATH

90 D 67453

1 PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2832 N. Calvert. ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Saur. Keene

(Residence in Baltimore: No. 2832 N. Calvert St. St. 80 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE White 5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Widower

6-DATE OF BIRTH 1840 (Month) (Day) (Year)

7-AGE 8 2 yrs. mos. ds. or min. If LESS than 1 day, hrs.

8-OCCUPATION (a) Trade, profession or particular kind of work Retiree (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Md

10-NAME OF FATHER Lewis Keene

11-BIRTHPLACE OF FATHER (State or country) Md

12-MAIDEN NAME OF MOTHER Ann Jones

13-BIRTHPLACE OF MOTHER Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel P. Keene Jr.

(Address) 2832 N. Calvert St.

16- Robert P. Harrison, REGISTRAR

Filed 191 1922 Burial Permit 4163

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from for several years, Sept 8, 1922, that I saw him alive on Sept 7, 1922, and that death occurred, on the date stated above, at 9:11 m.

The CAUSE OF DEATH* was as follows:

Thrombotic disease of the heart. (Duration) Several years

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) H. H. Gossel, M. D. 9-10-1922 [Address] 117 N. Calvert St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Bonora Bros. Cem. DATE OF BURIAL 11/11/22 191

20-UNDERTAKER J. J. Fahey Sons ADDRESS 1318 Light St.

67454
D 67454

HEALTH DEPARTMENT—CITY OF BALTIMORE

67454
D 67454

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *7* Ward)

2-FULL NAME

(Residence in Baltimore, No. *Cramerton N.C.* St.; yrs., mos., ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH

Aug (Month) *18* (Day) *88* (Year)

7-AGE

41 yrs. *1* mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- Librarian*
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

N.C.

10-NAME OF FATHER

Edward J. Mallon

11-BIRTHPLACE OF FATHER, (State or Country).

N.C.

12-MAIDEN NAME OF MOTHER

Jessie Hopton

13-BIRTHPLACE OF MOTHER, (State or Country).

N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Johns Hopkins Hosp*

(Address)

15-

Filed

SEP 11 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 9 192*2*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.)find that said deceased came to *death* (Inquest, autopsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

*Carcinoma Gastric**Autopsy performed at*
Hosp (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. S. B. Bates* M. D.

(Coroner.)

9-10 192*2* (Address) *508 E. North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore N.C. *Sept 10* 192*2*

20-UNDERTAKER

ADDRESS

Joseph Whrens *2218 B Way*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Hilbert St. 25 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 117 Hilbert St. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 10 mos. 24 ds.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day

hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 1922, to Sept 9 1922

that I last saw her alive on Sept 5 1922

and that death occurred, on the date stated above, at 10.30 A.M.

The CAUSE OF DEATH was as follows:

Enterocolitis

(duration) yrs. mos. 2 wks

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos B. Forton M. D.

19 (Address) Curtis Bay, Balto Md

State the Disease Causing Death, or in deaths from Violent Causes, state the Nature and Nature of Injury, and (2) whether Accidental, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

19066, Balto

SEP 11 1922

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D 67457

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2820 Fair Ave ST., 1 WARD)

2-FULL NAME

(a) RESIDENCE NO. 2820 Fair Ave ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John J Kena

6 DATE OF BIRTH (month, day, and year)

June 3, 1860

7 AGE

Years

Months

Days

62

3

8

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Ernst

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant (Address)

John J Kena 2820 Fair Ave

15

SEP 11 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 24, 1922, to Sept 8, 1922,

that I last saw her alive on Sept 7, 1922,

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Gastric - Carcinoma

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds. General & Landmark (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? urine

(Signed) Dr. R. C. Kramer, M. D.

10/9/1922 (Address) 125 E. B. Hwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

11 Evangelical Cem. Sept 11 1922

20 UNDERTAKER

ADDRESS

H. Sander Sons

1710 Reid St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67458

46 D 67458

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *640 Gutzman Ave* ST.; *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Annice Eliza West*(a) RESIDENCE. No. *640 Gutzman Ave* ST.; WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Louis G. M. West*6 DATE OF BIRTH (month, day, year) *August 8 1850*7 AGE Years *72* Months *0* Days *29* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md.*10 NAME OF FATHER *Alfred P. West*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Hartford Conn.*12 MAIDEN NAME OF MOTHER *Mother Leshon*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md.*14 Informant *Louis G. M. West* (Address) *640 Gutzman Ave.*15 Filed *SEP 11 1922* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sept 6 1922*17 I HEREBY CERTIFY, That I attended deceased from *July 28 1922* to *Aug 6 1922*that I last saw her alive on *Sept 6 1922*and that death occurred, on the date stated above, at *12 PM* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Geoffrey O. H. D.*Address *401 E. 25th St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cemetery

20 UNDERTAKER

H. Vander & Sons

DATE OF BURIAL

Sept 11 1922

ADDRESS

1710 Fleet St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 87459 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 76 JOHN'S HOPKINS HOSPITAL ST., 36 WARD)

2-FULL NAME

Charles W. Randolph(a) RESIDENCE No. 1101 Bouldin St ST., ? WARD(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of X6 DATE OF BIRTH (month, day, and year) June 24-19037 AGE Years 19 Months 2 Days 14 If LESS than 1 day, ? hrs. or ? min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Line-keeper(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)10 NAME OF FATHER Charles W. Randolph11 BIRTHPLACE OF FATHER (city or town) Ind (State or country)12 MAIDEN NAME OF MOTHER Rajina Mauer13 BIRTHPLACE OF MOTHER (city or town) Ind (State or country)14 Informant JOHNS HOPKINS HOSPITAL (Address)15 File SEP 11 1922 DR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 192217 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1922, to Sept 8, 1922 that I last saw him alive on Sept 8, 1922and that death occurred, on the date stated above, at 11:20 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis(duration) ? yrs. 3 mos. ? ds.CONTRIBUTORY Bilateral renal tuberculosis (Secondary) Unknown (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ?Was there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) Myron E. G. Oldblatt, M. D., 19 ? (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVING St. Agnes Cemetery DATE OF BURIAL Sept 11 192220 UNDERTAKER Joachim Syfer ADDRESS 1608 N. Hollen Ave

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*No pulmonary
tuberculosis.
Tuberculosis kidney.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67460

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 Linden Ave ST. 14 WARD)

REGISTERED NO. 67460

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Imogen George

(a) RESIDENCE. No. 1415 Linden Ave ST. 14 WARD. Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 0 mos. 28 ds. How long in U. S., if of foreign birth? 61 yrs. 0 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug-12-1861

7 AGE

Years 61

Months 0

Days 28

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer) Public Schools

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Baltimore Maryland.

10 NAME OF FATHER Andrew J. George

11 BIRTHPLACE OF FATHER (city or town) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Kate Bond

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Maryland

PARENTS

14 Informant Mrs Sarah George (sister) (Address) 1415 Linden Ave

15 Filed

19

SEP 11 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9. 1922

17 I HEREBY CERTIFY, That I attended deceased from June 1918, to Sept. 9. 1922, that I last saw her alive on Sept. 8. 1922, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Arthritis

(duration) 4 yrs. 3 mos. - ds.

CONTRIBUTORY (Secondary) Solar Pneumonia with Pleurisy (duration) - yrs. - mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Gibson Porter, M. D.

9/9, 1922 address 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Griffiths Family

20 UNDERTAKER

STEWART & MOWEN COMPANY 108 W. NORTH AVE

WILLIAM F. WOODEN, Successor

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67461

CERTIFICATE OF DEATH.

165 D 67461

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital, St. 14 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....WILMOT GRIFFISS

(Residence in Baltimore: No. 309-Oakdale-Road, (27-Ward) St.; yrs., 52-5-18 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, March 21 1870 (Month) (Day) (Year)

7-AGE, 52 yrs. 5 mos. 18 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Banker (b) General nature of industry, business, or establishment in which employed (or employer), (self)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Thomas J. Griffiss

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore, Md.

12-MAIDEN NAME OF MOTHER, Sophia Hitzell

13-BIRTHPLACE OF MOTHER, (State or Country), Germany.

11-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. W. Jacobsen (Bro-in-law) 309-Oakdale-Road, City. (Address)

15- Filed SEP 11 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 9, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows:

Richmond of Mercury Poison (suicide) (Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) and nephritis (Signed) J. E. J. Neumeyer, M. D. (Coroner.) Sept 10 1922 (Address) 200 E. Pratt St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death 0 yrs. 0 mos. 6 ds. In the 52 yrs. 5 mos. 18 ds.

Where was disease contracted, if not at place of death? 309-Oakdale-Road, City. Former or usual residence 309-Oakdale-Road.

19-PLACE OF BURIAL OR REMOVAL, LOUDON PARK CEMETERY. DATE OF BURIAL, Sept-11-1922.

20-UNDERTAKER, STEWART & MOWEN COMPANY ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67462

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *323 Collins Ave* ST. *70* WARD)

2-FULL NAME

(a) RESIDENCE. No. *323 Collins Ave* ST. *70* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? *30* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Husband

6 DATE OF BIRTH (month, day, and year) *Oct 16*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Flowerist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Guy Hutton

9 BIRTHPLACE (city or town) (State or country)

Ireland,

10 NAME OF FATHER

John Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Emt. Prine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mr. Shields 323 Collins Ave

15

SEP 11 1922

[Signature]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 9* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 6, 1922, to Sept 9, 1922,

that I last saw him alive on *Sept 9, 1922,*

and that death occurred, on the date stated above, at *7 a. m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. *3* ds.

CONTRIBUTORY *Cardiac Failure* (Secondary)

(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Physic. signs*

(Signed) *Henry J. Hahn* M. D.

9/9/1922 (Address) *73 W. Franklin St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

Sept 11 1922

20 UNDERTAKER

ADDRESS

John J. Fields 1200 W. Lombard

Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67463

CERTIFICATE OF DEATH.

D 67463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Murphy Hospital* ST., *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. *Murphy Hospital* ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 9, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, / hrs. or / min.

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Murphy Hosp. Bklyn. N.Y.

10 NAME OF FATHER

Robert Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Annelle Thumach

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Robert A. Schwartz 223 N. ...

15

Filed

SEP 11 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 10, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Sept 9, 1922, to Sept 10, 1922.

that I last saw him alive on *Sept 10, 1922,*

and that death occurred, on the date stated above, at *11 P.M.*

The CAUSE OF DEATH* was as follows:

Fractured Skull.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Fractured Skull

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *Yes Partial*

What test confirmed diagnosis? *Autopsy*

(Signed) *Samuel J. Rosenberg, M.D.*

, 19 (Address) *Murphy Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cemetery Sept 11 1922

20 UNDERTAKER

ADDRESS

For Gardens & Son 217 S. ...

D 67464 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 5

1-PLACE OF DEATH

CITY OF BALTIMORE: No

316 Calver

ST.: 5

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Bright

(a) RESIDENCE. No

316 Calver

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

William H. Bright

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Virginia

10 NAME OF FATHER

William Nailor

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Unknown

14

Informant
(Address)William H. Bright
316 Calver St.

15

Filed

SEP 11 1922

J. E. Thomas

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 4 1922, to Sept 8 1922,

that I last saw her alive on Sept 7 1922,

and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial
nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. E. Thomas M. D.
9.11.1922 Address 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Faunal Bur

Sept 11 1922

20 UNDERTAKER

ADDRESS

Mrs. R. A. Elliott

Ashland

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67465

CERTIFICATE OF DEATH.

90 D 67465

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 W. Bradford ST. WARD 8)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 1213 W. Bradford ST. WARD 8

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of late Annie Runzheimer (or) WIFE of6 DATE OF BIRTH (month, day, and year) April 1st 18457 AGE Years 77 Months 5 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Not Known11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Elizabeth Runzheimer (Address) 1213 W. Bradford ST.15 Filed SEP 11 1922 19 MA 7. C Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8th 192217 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1922 to Sept 8, 1922 that I last saw him live on Sept 8, 1922and that death occurred, on the date stated above, at 7:55 a. m.

The CAUSE OF DEATH* was as follows:

acute
Myocardial Regurgitation
infant, Paralysis
CONTRIBUTORY, acute Cardiac Depletion
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted unknown if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? FindingsSigned [Signature] M. D.
19 (Address) 800 N. Pratt St. Rm 102

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Balto. CemeterySept. 11 1922

20 UNDERTAKER

ADDRESS

Lilly Green800 N. Pratt St.

Physician should state EXACTLY. Exact statement of Occupation should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

67466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1226 Penn ST. Yan WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Rebecca Gant(a) RESIDENCE. NO. 1226 Penn ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female4 COLOR OR RACE negro5 Single, Married, Widowed, or Divorced (write the word) widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of widow6 DATE OF BIRTH (month, day, and year) Sept 7 1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 53 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.10 NAME OF FATHER John Warner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Calvert Co Md12 MAIDEN NAME OF MOTHER Annie Warner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Washington D.C.

14

Informant Serge T Gant(Address) 359 E. Preston St.

15

Filed SEP 11 1922

19

M. J. A.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 26, 1922, to Sept 8, 1922,that I last saw her alive on Sept 8, 1922,and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Asthma(duration) yrs. 1 mos. ds.CONTRIBUTORY (Secondary) Branchitis(duration) yrs. 1 mos. ds.18 Where was disease contracted if not at place of death? Balto MdDid an operation precede death? no Date of —Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. R. Boykin, M. D., 19 (Address) 1618 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1701Burns & Pugh

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67467

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67467

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 803 S. Charles Street. St. 23 Ward)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Won Lee.

(Residence in Baltimore: No. 803 S. Charles St. St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE. Yellow. 5-Single, Married, Widowed, or Divorced. Single (Write the word.)

6-DATE OF BIRTH. Do not know. (Month) (Day) (Year)

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Laundryman. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). China.

PARENTS. 10-NAME OF FATHER. Do not know. 11-BIRTHPLACE OF FATHER, (State or Country). Do not know. 12-MAIDEN NAME OF MOTHER. Do not know. 13-BIRTHPLACE OF MOTHER, (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) William Wen. (Address) 210 Ivory Al.

15-Filed. 11 1922 10? M 7 9 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. September 9, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above. The CAUSE OF DEATH* was as follows:

Organic disease of the heart & Kidneys.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) J. M. P. M. D. (Coroner) Sept. 10, 1922. (Address) 1014 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cem. DATE OF BURIAL. Sept 11, 1922

20-UNDERTAKER. John Fox Denney ADDRESS 715 Light St

D 67468

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67468

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2229 E. Madison ST., WARD)

2. FULL NAME

(a) RESIDENCE NO. 2229 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Marion McKee

6 DATE OF BIRTH (month, day, and year)

Years Months Days

If LESS than 1 day, hrs. or min.

7 AGE

48 10 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

At home

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Mr. G. Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Louise Luckhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Louise Meyer

2229 E. Madison ST., WARD

SEP 11 1922

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1922

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to Sept. 10, 1922.

that I last saw her alive on Sept. 10, 1922, 5:25 P.M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus (Inoperable)

CONTRIBUTORY (Secondary)

(duration) yrs. 5 mos. ds.

Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1922

Was there an autopsy?

What test confirmed diagnosis?

Exploratory laparotomy

(Signed) Wm. J. Schnitz M. D.

19 (Address) 701 N. Howard Ave.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL Baltimore

20 UNDERTAKER

Zerkler & Zerkler

DATE OF BURIAL

Sept 12 1922

ADDRESS 1734

Eager

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D. 67470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 67470

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 728 Grindall Court. St. 24 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Alice Johnson.(C).

44

(Residence in Baltimore: No. 728 Grindall Court. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, (Write the word.) Married.

6-DATE OF BIRTH.

Do not know.

(Month) (Day) (Year)

7-AGE,

62

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Virginia.

PARENTS.

10-NAME OF FATHER.

William Carter.(C).

11-BIRTHPLACE OF FATHER, (State or Country).

Virginia.

12-MAIDEN NAME OF MOTHER.

Ananda Thompson (C).

13-BIRTHPLACE OF MOTHER, (State or Country).

Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary James.(C).(sister).

(Address) 728 Grindall Court.

15-

Filed

SEP 11 1922

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

September 9, 1922.

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I, took charge of the

remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart & Kidneys.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Sept. 10, 1922. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS

R. L. Pahan

220 N. Main

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67471

D 67471

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept 10 4 PM 19 22, to Sept 10 7 PM 19 22.

that I last saw him alive on Sept 10 19 22.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Est home

Did an operation precede death? Yes Date of Sept 10-1922

Was there an autopsy? No

What test confirmed diagnosis? Clinically operative

(Signed) James Hubert Dickerson M. D.

19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem. Sept 14 19 22

20 UNDERTAKER

ADDRESS

Joseph B Cook 1003 N. Balto St.

PHYSICIANS should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

P 111922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67472

CERTIFICATE OF DEATH

41 D 67472

1-PLACE OF DEATH

Union Memorial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 14 WARD)

2-FULL NAME

Edward M. Parks

(a) RESIDENCE. No.

1622 Mt. Royal Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary Parks.

6 DATE OF BIRTH (month, day, and year)

Sept. 24 1890

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

31

11

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Police officer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Police dept.

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland

10 NAME OF FATHER

William Parks

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va -

14

Informant

Mary Parks

(Address)

1521 John St.

15

Filed

Robert F. Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 4, 1922, to Sept 10, 1922,

that I last saw him alive on Sept 10, 1922,

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Secondary Pneumonia
to Streptococcus Septicemia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY
(Secondary)

Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood cultures

(Signed) O. B. Price, M. D.

9/11/22 address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral Cem

Sept 12 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Baltimore

PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

SP 1 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67473

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 Bata Ave ST. 10 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 629 Bata Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S. if of foreign birth

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from SEPT. 3, 1922, to SEPT. 10, 1922.

that I last saw him alive on SEPT. 10, 1922.

and that death occurred, on the date stated above, at 12:00 P.M.

The CAUSE OF DEATH* was as follows:

the valvular heart disease myocardial infarct.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John L. Torsey, M. D.

, 19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

SEP 11 1922

J. Torsey, 1008 Cathedral St.

Vonnahme Sept 13 1922
William back 502 N. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67474

90 D 67474

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Daniel J. Messinger, M. D.

90, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

PHYSICIANS should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

P 1 1922

Robert P. Lattimore,

19

Burial Permitted Clerk,

Registrar

D 67475

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1412 Retreat St St. 13 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles R. Jones(Residence in Baltimore: No. Druid Place Park St.; yrs. 5 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-Single, Married, Widowed, or Divorced. Married
(Write the word.)6-DATE OF BIRTH. April 5 1873
(Month) (Day) (Year)7-AGE. 49 yrs. 5 mos. 4 ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work Supt. Cty. of Public Parks
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country) Baltimore Md10-NAME OF FATHER, Robert L. Jones11-BIRTHPLACE OF FATHER, (State or Country) Maryland12-MAIDEN NAME OF MOTHER, Susan Fields13-BIRTHPLACE OF MOTHER, (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella M. Jones(Address) Druid Place Park

15-

Robert P. Harrison,

192

Registrar.

Burial Park142 Morrissey Road An

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 9 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above. The CAUSE OF DEATH was as follows:
Asphyxiation
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Harrison M. D.
(Coroner.)*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
1612 Retreat St

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence. yrs. mos. ds.

19-DATE OF BURIAL. Sept 12 1922

20-UNDERTAKER, ADDRESS

William Cook - 502 E. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67476 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

178 D 67476

1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin Square 368* St. *14* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Everett P. Curtis*

(Residence in Baltimore: No. *115 N. Carrollton* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH. *Nov 13* 19*11*
(Month) (Day) (Year)

7-AGE. *10* yrs. mos. ds. If LESS than 1 day. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *child*
(b) General nature of industry, business, or establishment in which employed (or employer) *000*

9-BIRTHPLACE, (State or Country), *Balto Md*

10-NAME OF FATHER, *Cornelius B Curtis*

11-BIRTHPLACE OF FATHER, (State or Country), *Balto Md*

12-MAIDEN NAME OF MOTHER, *Effie L. Brown*

13-BIRTHPLACE OF MOTHER, (State or Country), *Balto Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Effie Curtis*

(Address) *115 N. Carrollton*

15.

1922 *Robert P. Harrison,*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 11* 19*22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *lung* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Congestion of Kidney with Suppression of Urine follow swimming in pool

(Duration) yrs. mos. ds.

CONTRIBUTORY *urinary complications* (Secondary)

(Duration) yrs. mos. ds.

(Signed) *John H. Carter* M. D. (Coroner.)

Sept 11 19*22* (Address) *700 E. Chancery*

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *Franklin Square 368* In the of death. yrs. mos. ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

115 N. Carrollton

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Park *Sept 13* 19*22*

20-UNDERTAKER, ADDRESS

Wm Cook *502 E North*

Dr Henton

D 67477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Washington Ave ST. 27 WARD)2-FULL NAME Gertrude C. Crook.(a) RESIDENCE NO. 2 Washington Ave ST. 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of T. Oliver Crook.6 DATE OF BIRTH (month, day, and year) Nov 5, 18807 AGE Years 42 Months 10 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) MD10 NAME OF FATHER Chas J Menzel11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)12 MAIDEN NAME OF MOTHER Batchlor13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14

Informant T. Oliver Crook (Address) 2 Washington Ave

15

Robert P. Harrison, Registrar

SEP 11 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct., 19 21, to Sept 9, 19 22that I last saw him alive on Sept 9, 19 22and that death occurred, on the date stated above, at 6:45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Lloyd M. D., 19 (Address) 2232 Euton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mr. Oliver

FUNERAL TAKER

John Drlich

DATE OF BURIAL

Sept-12 19 22

ADDRESS

2008 Orleans

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67478

D 67478

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2742 E Chase ST. 8 WARD)

2. FULL NAME

Elizabeth De Salvo

(a) RESIDENCE NO.

2742 E Chase ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Dominick De Salvo

6 DATE OF BIRTH (month, day, and year)

Sept 10 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy

10 NAME OF FATHER

Jo Costoli

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Jo De Salvo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Jo De Salvo
2742 E Chase

15

Robert E. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 192217 I HEREBY CERTIFY, That I attended deceased from July 6 1922 to Sept 10 1922that I last saw him alive on Sept 10 1922and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
stomach

CONTRIBUTORY (Secondary)

Carcinoma of
stomach

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Michael J. Ryan M. D.1977 (Address) 18004 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cen

20 UNDERTAKER

John Blinch

DATE OF BURIAL

Sept 13 1922

ADDRESS

200 E. Enoch

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 11 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67479

CERTIFICATE OF DEATH.

D 67479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Municipal Tuberculosis Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Blanche McFarland(a) RESIDENCE NO. 326 S. 13th st.

ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds.

How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____ 4 COLOR OR RACE _____ 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofSeigel McFarland6 DATE OF BIRTH (month, day, and year) 1886

7 AGE _____ Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

36

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____ House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____ (State or country) _____

Ohio10 NAME OF FATHER Desire Pillot

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____

France12 MAIDEN NAME OF MOTHER Flavie Tournoux

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____

France

14

Informant Hospital Records
(Address) M. T. H.

15

SEP 11 1922

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1922, to Sept. 11, 1922.that I last saw her alive on Sept. 11, 1922.and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 1 yrs. 5 mos. _____ ds.CONTRIBUTORY Spontaneous pneumo-
(Secondary) thorax (duration) _____ yrs. _____ mos. 21 ds.18 Where was disease contracted _____ if not at place of death? UnknownDid an operation precede death? No Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis J. Delaplace M. D.9-11-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALSacred Heart Cemetery

20 UNDERTAKER

John Dellich

DATE OF BURIAL

Sept 14 1922

ADDRESS

2000 Hillman

B. — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Jorn)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67480

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emma Zorn

(a) RESIDENCE NO.

22 N. Clinton

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

7

6 DATE OF BIRTH (month, day, and year)

Mar. 1895

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

27

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Wm. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Corea Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W. Baltimore Co.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

1-1922

Robert F. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 17, 1922 to Sept 10, 1922.

that I last saw her alive on Sept 10, 1922

and that death occurred, on the date stated above, at 5²⁴ a. m.

The CAUSE OF DEATH* was as follows:

Bacterial Endocarditis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? 21

What test confirmed diagnosis?

(Signed) Chas. Rebusch M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Oak Lawn Cem

20 UNDERTAKER

John Sullivan

DATE OF BURIAL

Sept 1922

ADDRESS

208 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67481

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Franklin Ave ST., 27 WARD)

2-FULL NAME Charles Thomas Johnson

(a) RESIDENCE NO. 18 Franklin Ave ST., 27 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Johnson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years 63 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Green Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schuldmann

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Saul P Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Joan Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary A Johnson (Address) 18 Franklin Ave

15 Robert J. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1921, to Sept 11, 1922, that I last saw him alive on Sept 11, 1922, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Dist. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. Symptom

(Signed) C. C. Schenck, M. D.

, 19 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mount Olivet Cem

DATE OF BURIAL

Sept 11 22

20 UNDERTAKER

John Dellerich

ADDRESS

2008 Orleans

Burial Permit 61617

D 67482

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67482

1. PLACE OF DEATH

CITY OF BALTIMORE, No.

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

1922

Registrar

CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from 9-3-22, to 9-9-22

that I last saw h. alive on 9-9-22

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis with stones & perforated gall bladder

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 9-6-22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. O. W. Daniel, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Sept 12 1922

20 UNDERTAKER ADDRESS

Harry H. Witzke 1531 W. Lombard

D 67483

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67483

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 915 S. Sharp ST. 23 WARD)

2. FULL NAME

Solomon Williams

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

915 S. Sharp

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced. (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lorise Williams

6 DATE OF BIRTH (month, day, and year)

1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Driving wagon

(c) Name of employer

Over snow

9 BIRTHPLACE (city or town) (State or country)

Saunder Co. Virginia

10 NAME OF FATHER

Scott Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Saunder Co. Virginia

12 MAIDEN NAME OF MOTHER

Julia Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Saunder Co. Virginia

14

Informant (Address)

Charles Williams 238 1/2 N. Bond St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 10, 192217 I HEREBY CERTIFY, That I attended deceased from Aug, 31, 1922, to Sept, 10, 1922, that I last saw him alive on Sept, 10, 1922, and that death occurred, on the date stated above, at 7:50 P. M.

The CAUSE OF DEATH* was as follows:

Acute Diffuse Nephritis (Terminal, uraemia)

CONTRIBUTORY (Secondary)

(duration) — yrs. 2 mos. — ds.Chronic Endocarditis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Cast & albumen

(Signed)

Davis Francis M. D.9/11, 1922 Address 1211 N. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVING

MT Auburn et -April 13, 1922

20 UNDERTAKER

C. L. Brown & Son

ADDRESS

108 N. Montg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67484

CERTIFICATE OF DEATH.

D 67484

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 E. Church ST. 74 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 6 E. Church St.; 17 yrs., 12 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE, col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, married
(Write the word.)

6-DATE OF BIRTH, Sept. 9, 1922
(Month) (Day) (Year)

7-AGE, 86 yrs., 12 mos., 12 ds. If LESS than 1 day,hrs. ormin.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

PARENTS.
10-NAME OF FATHER, Jos. Parker
11-BIRTHPLACE OF FATHER (State or Country), Va.
12-MAIDEN NAME OF MOTHER, Mary Bailey
13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Parker (wif.)(Address) 6 E. Church St.

15-

Filed Robert P. Harrison, Registrar.1922 Partial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 9, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 7, 1922, to Sept. 8, 1922, that I saw him alive on Sept. 5, 1922, and that death occurred, on the date stated above, at 11:20 P.M.
The CAUSE OF DEATH* was as follows:
Paralysis

(Duration)yrs.mos.ds.
CONTRIBUTORY (Secondary) (Duration)yrs.mos.ds.

(Signed) J. F. Shumway M. D.
Sept. 11, 1922 (Address) 2225 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAVELERS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Ct. DATE OF BURIAL, Sept. 14, 1922

20-UNDERTAKER, Chas. Brown & Son ADDRESS, 108 W. Montgomery St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Terminal cerebral hemorrhage

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

D 67485

HEALTH DEPARTMENT—CITY OF BALTIMORE

67485

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. Joseph Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No. *N. Caroline*)ST.: *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *William Amos*(a) RESIDENCE. No. *Sharon, Hartford Co. Md.* ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 9 1918

7 AGE

4 Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Sharon, Hartford Co. Md.

10 NAME OF FATHER

Elwood Amos

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Harford Co. Md.

12 MAIDEN NAME OF MOTHER

Eleanor Green

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Sharon, Hartford Co. Md.

14

Informant (Address)

Elwood Amos, Sharon, Md.

15

Filed

No. 19

W. P. Harrison

Registrar

1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 11, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug. 31, 1922*, to *Sept. 11, 1922*, that I last saw him alive on *Sept. 11, 1922*, and that death occurred, on the date stated above, at *6 P.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *H. A. Schumich*, M. D.19 (Address) *St. Joseph's Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Harford Co. Md. Fairview Cemetery

DATE OF BURIAL

Sept. 13 1922

20 UNDERTAKER

Elk Kurtz & Son

ADDRESS

Harford Co. Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated, EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Broncho.

No infection prior

20.67486 HEALTH DEPARTMENT—CITY OF BALTIMORE

20.67486

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

ST. 3 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 14, 1922, to Sept. 10, 1922, that I last saw him live on Sept. 10, 1922, and that death occurred, on the date stated above, at 10:30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumo. Pneumonia (terminalis)

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

9/13/22 Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

SEP 14 1922

11. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 15 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67487

CERTIFICATE OF DEATH.

D 67487

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 N Port ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Frank Modicka

(a) RESIDENCE No.

518 N PortST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

35 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Rose Modicka

6 DATE OF BIRTH (month, day, and year)

Feb 2 - 1873

7 AGE

49 Years

Months

6

Days

8

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

White cleaner

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

city

9 BIRTHPLACE (city or town) (State or country)

Carpenter

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Carpenter

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Carpenter

14

Informant (Address)

Rose Modicka
518 N Port St

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

May 10 1922 to Sept 10 1922that I last saw him alive on Sept 10 1922and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus(duration) yrs. 6 mos. ds.CONTRIBUTORY Cardiac & RespiratoryParalysis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Radio graph(Signed) Albert D. Hesser, M. D.Sept 11 1922 (Address) 1211 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Hill CemeterySept 13 1922

UNDERTAKER

James T. Hanley

ADDRESS

15 N. Washington

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item entered should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67488

67488

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 100 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Blackstone(a) RESIDENCE NO. Unknown 4116 Fort St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18337 AGE Years Months Days If LESS than 1 day, hrs. or min. 89 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant

Hospital Records.

(Address)

Municipal Hospital.

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 19 22

17

I HEREBY CERTIFY, That I attended deceased from September 6, 19 22, to September 9, 19 22.that I last saw her alive on September 9, 19 22.and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumoniaCONTRIBUTORY (Secondary) Senility (duration) yrs. mos. ds.

(duration) ? yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

9/11/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67489

67489

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *711 W Lafayette Ave* ST. *17* WARD)

2-FULL NAME

William Rachel Warfield

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *711 W Lafayette Ave* ST. *17* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

79

Years

4

Months

Days

*1*If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Comptroller

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore**Med*

10 NAME OF FATHER

William Warfield

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Crownsville, Md

12 MAIDEN NAME OF MOTHER

Ann Jane Kuyper

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

*Baltimore**Med*

14

Informant
(Address)*Mrs. Adah Warfield*
711 W Lafayette Ave

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 10* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Sept, 19 *19*, to *Sept 10*, 19 *22*.that I last saw him alive on *Sept 10*, 19 *22*.and that death occurred, on the date stated above, at *9:20 P. m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum(duration) *3* yrs. mos. ds.CONTRIBUTORY
(Secondary)(duration) *12* yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *James M. Harrison*, M. D., 19 (Address) *Crownsville, Md.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*711 W Lafayette Ave**Sept 12* 19 *22*

20 UNDERTAKER

Adie M. Walker

ADDRESS

723 W Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67490

D 67490

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE (No. _____)

2. FULL NAME

3. RESIDENCE No. _____

(Usual place of abode)

Length of residence in city or town where death occurred

52 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

9-7-22 to 9-11-22 that I last saw him alive on 9-11-22

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Strangulation of Ventral Hernia

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 9-8-22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. C. Caldwell, M. D. (Address) St Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

EDMONDSON AVE.

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67491

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Ellamont ST., 15 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Calvert Slaughter

(a) RESIDENCE NO. 1726 Ellamont ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 5th, 1887

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 34 11 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Dupont Construction Co

9 BIRTHPLACE (city or town) Trappe Md. (State or country)

10 NAME OF FATHER William F. Slaughter

11 BIRTHPLACE OF FATHER (city or town) Trappe Md (State or country)

12 MAIDEN NAME OF MOTHER Eliza Jane Henry

13 BIRTHPLACE OF MOTHER (city or town) Trappe Md (State or country)

14 Informant Mrs Eliza J. Slaughter (Address) 1726 Ellamont St.

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11th, 22

17 I HEREBY CERTIFY, That I attended deceased from August 24, 1922, to Sept. 11, 1922, that I last saw him alive on September 11, 1922, and that death occurred, on the date stated above, at 7.15 A. m. The CAUSE OF DEATH* was as follows:

Spleno-Myelogenous Leukaemia

(duration) 1 yrs. 6 mos. ds. CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) Henry T. Collenberg, M. D.

9/11, 1922 (Address) 3103 Clifton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

Sept 13, 1922

20 UNDERTAKER

ADDRESS

Vertram 1076

1723 1/2 St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67492

CERTIFICATE OF DEATH.

90 D 67492
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2606 Huntingdon ST., 12 WARD)

2-FULL NAME

Samuel Raver

(a) RESIDENCE NO.

2606 Huntingdon ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male white Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Georgia Raver

6 DATE OF BIRTH (month, day, and year) 10-28-1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71 10 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Car Cleaner 040

(b) General nature of industry, business, or establishment in which employed (or employer)

United Elec Ry Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

John Raver

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant (Address)

Annie Conner

2606 Huntingdon Ave

15

Filed

Robert P. BARTLE

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-9-1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 26, 1922, to Sept 9, 1922.

that I last saw him alive on Sept 7-1922, 19

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) S. J. Buxton, M. D.

9/9/1922 (Address) 301 E Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

H Marys Hampden

Sept 12 1922

20 UNDERTAKER

ADDRESS

W. M. Routon

2238 12

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67493

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 67493

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Monument St

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Julia Freund

(a) RESIDENCE. NO. Hebrew Aged Home Monument St

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jacob Freund

6 DATE OF BIRTH (month, day, and year)

Jan. 16-1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Austria

10 NAME OF FATHER

Jacob Stein

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Benj. S. Freund 123 Monument St. D. C.

15

Filed

SEP 12 1922

Robert P. Harrison

Registrar

Burial Permit 0112

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 4 1922, to September 10, 1922, that I last saw him alive on September 10, 1922, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage following Pulmonary Tbc.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Diabetes Mellitus (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine-Blood

(Signed) Louis Sachs M. D.

9/10, 1922 (Address) The Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Har. Sinai Cemetery

Sept 12 1922

20 UNDERTAKER

ADDRESS

William G. Schaeffer 1816 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67494 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST. *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Margaret O'Donnell*

(a) RESIDENCE NO. *1513 Hoffmann* ST. *8* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *31* yrs. — mos. — ds. How long in U. S., if of foreign birth? *31* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced *Widow of late John O'Donnell* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 16*

7 AGE *44* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Matron at 188*

(b) General nature of industry, business, or establishment in which employed (or employer) *High St Bath House*

(c) Name of employer

9 BIRTHPLACE (city or town) *Ireland* (State or country)

10 NAME OF FATHER *Charles M'Fenna*

11 BIRTHPLACE OF FATHER (city or town) *Ireland* (State or country)

12 MAIDEN NAME OF MOTHER *Elizabeth Trainor*

13 BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or country)

14 Informant *Miss Mary B. O'Donnell* (Address) *1513 E Hoffmann*

SEE 121922 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 10 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Aug 30 1922* to *Sept 10 1922*

that I last saw her alive on *Sept 10 1922*

and that death occurred, on the date stated above, at *7:10 p. m.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Cholecystitis*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *Sept 8, 22*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *D. W. Murray* M. D.

. 19 (Address) *St. Joseph's Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

20 UNDERTAKER

Henry Hoeck, Inc.

DATE OF BURIAL

Sept. 13 1922

ADDRESS

1301 E Bayview

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Henrietta F. W. Bergmann

67495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *934 E Biddle* ST., *10* WARD)

2. FULL NAME *Henrietta F. W. Bergmann*

(a) RESIDENCE NO. *934 E Biddle* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *27* yrs. — mos. — ds. How long in U. S., if of foreign birth? *27* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb. 29 1868*

7 AGE Years *68* Months *6* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)

10 NAME OF FATHER *Not Known*

11 BIRTHPLACE OF FATHER (city or town) *Not Known* (State or country)

12 MAIDEN NAME OF MOTHER *Not Known*

13 BIRTHPLACE OF MOTHER (city or town) *Not Known* (State or country)

14 Informant *M. Frederick Bergmann* (Address) *934 E Biddle St.*

15 *SEP 12 1922* Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 11 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept. 1, 1922* to *Sept. 11, 1922*, that I last saw him alive on *Sept. 10, 1922*, and that death occurred, on the date stated above, at *5:40 p.m.* The CAUSE OF DEATH* was as follows: *Myocardial degeneration*

(duration) *2* yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *None*

Was there an autopsy? *No*

What test confirmed diagnosis? *None* (Signed) *H. Lee Wagner*, M. D.

9.11.1922 (Address) *1206 E. Preston*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Under Park Emery *SEP 13 1922* *Henry Woodruff* *1301 E. Bayview*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67496

CERTIFICATE OF DEATH.

D 67496

1. PLACE OF DEATH

CITY OF BALTIMORE, NO.

ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 9 ds. How long in U. S., if of foreign birth? 1/2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2nd 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

6

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt.

10 NAME OF FATHER

Leonard C. Lehr

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt.

12 MAIDEN NAME OF MOTHER

Marie A. Garriga

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt.

14

Informant

(Address)

Am. Leonard C. Lehr
Park Heights & Mylie Ave

15

File

SEP 12 1922

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 6 1922 to Sept 11 1922

that I last saw him live on Sept 11 1922

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Bilateral)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

James S. Apleman, M. D.

(Address)

4012 Park Heights av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western Cemetery

Sept 13 1922

20 UNDERTAKER

ADDRESS

Henry Hord & Son

1301 E. Eager

Burial Permit Closed

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67497

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sister of the Poor ST.: 10 WARD)

2-FULL NAME Margaret McGill

(a) RESIDENCE. NO. Preston Valley St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow of

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thomas McGill

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days

Unknown 71 years

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Canada

10 NAME OF FATHER

Wm. Ponce

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Elizabeth Wray

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant Sister Ference

(Address) Little Sister of the Poor, Robert P. Harrison,

15

Filed . 19

SEP 12 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1922

17 I HEREBY CERTIFY That I attended deceased from to second, 1922, to 1922.

that I last saw her alive on Sept 10, 1922.

and that death occurred, on the date stated above, at 11¹⁰ a.m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

19 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral

Sept 12 1922

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 67498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs. 5 mos. 11 ds.

How long in U. S., if of foreign birth?

Yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

4-1-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

5

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

East Brooklyn, Md

10 NAME OF FATHER

John Harvath

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hungary

12 MAIDEN NAME OF MOTHER

Auna Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hungary

14

Informant (Address)

John Harvath East Brooklyn

15

Filed

19

Registrar

Digital Permit Clerk

Horvath

D 67498

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 8, 1922, to Sept 10, 1922,

that I last saw him alive on

Sept 10, 1922

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Harkay, M. D.

Address

Curtis Bay, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

Holy Cross A C Co

9-13 1922

Geo B Harle

ADDRESS

115 E West St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67499

D 67499

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 Eastman ST.; 3 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1528 Eastman St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stephen Brykowsky

(Address) 1528 Eastman St.

15-

Filed.

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 11, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 4 1922, to Sept 10 1922, that I saw her alive on Sept 10 1922, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Erysipelas (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Infection (Duration) yrs. mos. ds.

(Signed) S. Sadowski M. D.

Sept 12, 1922 (Address) 722 S. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS,

SEP 21 1922

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 67500

D 67500

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1113 E Mount St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1113 E Mount St. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE, White 5-Single, Married, Widowed or Divorced, (Write the word.)

6-DATE OF BIRTH, June 17 1880 (Month) (Day) (Year)

7-AGE, 42 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION. (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) (Address)

15- Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said. (Inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) (Coroner) (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 1922

20-UNDERTAKER, ADDRESS

67501
D 67500

HEALTH DEPARTMENT—CITY OF BALTIMORE

67501
D 67500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 Eutaw Ave)

2-FULL NAME

(Residence in Baltimore: No. 21 Eutaw Ave

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH.

March 28, 1875

7-AGE.

47 yrs. mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 12, 1912

I HEREBY CERTIFY, That I attended deceased from

that saw him alive on Sept 11, 1912

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Congestion bowels

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 12 1912

21922

Robert P. Harrison, Registrar.

18-PLACE OF BURIAL OR REMOVAL.

Fairview

DATE OF BURIAL.

Sept 15, 1912

19-UNDERTAKER.

R. P. Harrison

ADDRESS

1442

N. Rodway

Remarks

*Worked at grindstone & ten years ago
hurt himself & has never been well since.
Phy. only attends 3 days & could give no further
definite history.*

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

67502 HEALTH DEPARTMENT—CITY OF BALTIMORE
D 67501

CERTIFICATE OF DEATH.

67502
113 D 67501

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 2003 E Biddle St. WARD 8

2-FULL NAME Ida May Jones

(a) RESIDENCE. NO. 2003 E Biddle St. WARD 8
(Usual place of abode)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH April 10 1922
7 AGE Years 5 Months 1 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Howard A Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto
12 MAIDEN NAME OF MOTHER Lillie Cole
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

PARENTS

14 Informant (Address) Lillie Jones 2013 E Biddle St

15 Filed 1922 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 24 1922, to Sept 10 1922, that I last saw her alive on Sept 11 1922, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows: Gastro-Enteritis

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam
(Signed) J. W. Harrison M. D.

(Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Balto. Cemetery 9/13/22

20 UNDERTAKER ADDRESS

Geo. J. Roth 1735 N. Howard Ave

Spec.—1-10-21—M&T—1500 Rks.

38 D 67503

38 D 67503

1. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 67503

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Robt Garrett Hosp*
CITY OF BALTIMORE: (No. *27 N. Carey* ST., *16* WARD)
2-FULL NAME *Milton Doggett*
(a) RESIDENCE No. *1428 N. Lanvale* ST., _____ WARD _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. *8* mos. *27* ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS
3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) *Dec. 16 1921*
7 AGE Years *8* Months *27* Days _____ If LESS than 1 day, _____ hrs. or _____ min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*
10 NAME OF FATHER *Ch Doggett*
11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) *Va*
12 MAIDEN NAME OF MOTHER *B. Slater*
13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) *Va*

14 Informant *Ch Doggett* (Address) *1428 N. Lanvale St*

15 *Robert P. Harrison,* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 12 1922*
17 *Aug 11*
I HEREBY CERTIFY, That I attended deceased from *Aug 11*, 19 *22* to *Sept 12*, 19 *22*, that I last saw him alive on *Sept 12*, 19 *22*, and that death occurred, on the date stated above, at *11 A. m.*
The CAUSE OF DEATH* was as follows:

Rachitis & Syphilis
Hereditary
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY *Diarrhoea* (Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted *unknown* if not at place of death?

Did an operation precede death? *no* Date of _____

Was there an autopsy? *no*

What test confirmed diagnosis? *Blood Lab & Paps*

(Signed) *J. W. Clark*, M. D.

9/12 19 22 Address *27 N Carey*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *Millenbeck, Va* DATE OF BURIAL *Sept 12 22*

20 UNDERTAKER *Joseph B. Cook* ADDRESS *1003 M. St*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67505 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67505

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH
CITY OF BALTIMORE: No. 606 N. Fremont St., 16 WARD

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Lange

(a) RESIDENCE NO. 606 N. Fremont St., WARD _____
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Lange

6 DATE OF BIRTH (month, day, and year) Sept 2, 1846

7 AGE Years 76 Months 0 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Christian Lange

(Address) 606 N. Fremont St.

Filed Sept 13, 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to Sept 11, 1922, that I last saw him alive on Sept 10, 1922,

and that death occurred, on the date stated above, at 1309 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leonard M. Underhill, M. D.

(Address) 800 Harlem Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR BY MOVAL Roudon Park

DATE OF BURIAL Sept 13, 1922

20 UNDERTAKER Wm. J. Tucker

ADDRESS 1000 N. ...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

67506 HEALTH DEPARTMENT—CITY OF BALTIMORE 67506
D 67506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST.: *9* WARD)

2-FULL NAME

(a) RESIDENCE. No. *St. Mary's Rectory Annapolis Md.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *June 11 1844*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78

4

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Clerk 009

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

(Address)

Ben L. Hopping
Annapolis Md.

15

Filed

19

Registrar

SEP 13 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 12 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 11, 1922, to Sept. 12, 1922

that I last saw him alive on *Sept. 12, 1922*

and that death occurred, on the date stated above, at *3:57 PM*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration)

yr.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yr.

mos.

ds.

Chronic Nephritis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

19

(Address)

J. A. Schenck M. D.
St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery

Sept 15 1922

20 UNDERTAKER

ADDRESS

B L Hopping

Annapolis Md

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3023 Windsor Ave.)

WARD)

2-FULL NAME

Charles H. L. Stoetzer

(Residence in Baltimore: No. 3023 Windsor

St.; 66 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male white

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

March 11, 1847

7-AGE,

75 yrs. 6 mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired Salesman
the Leader9-BIRTHPLACE,
(State or Country),

Germany

10-NAME OF FATHER,

Hans Stoetzer

11-BIRTHPLACE OF FATHER
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Charlotte Kelleman

13-BIRTHPLACE OF MOTHER
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Minnie L. Stoetzer

(Address)

3023 Windsor Ave.

15-

Filed..... 191.....

SEP 13 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 10, 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

FEB 1 1922

191

to SEP 10 1922

191

that I saw him alive on

SEP 10 1922

191

and that death occurred, on the date stated above, at 10³⁰ p m.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

Chronic Nephritis

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... D.

SEP 12 1922 (Address) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lorraine Cemetery

Sept. 13, 1922

20-UNDERTAKER

ADDRESS

Messrs John H. Peufels

801 W. Fayette

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67508

CERTIFICATE OF DEATH.

44 67508

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5323 Senmore Ave 27 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Geo H. Gillespie

(a) RESIDENCE

No. 5323 Senmore Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

78 yrs.

2 mos.

8 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary J. Gillespie

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

68

21

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Manuel Gillespie

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Elizabeth Lowery

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant
(Address)Mary J. Gillespie
5323 Senmore Ave

15

Filing

SEP 13 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 10, 1922, to Sept. 11, 1922

that I last saw him alive on Sept. 11, 1922

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Leucemia of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed)

Theodore J. Morrison M. D.

, 19 (Address)

1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Spring Ridge Cem

DATE OF BURIAL

9/12 1922

20 UNDERTAKER

Geo. J. Smith

ADDRESS

1006 W. 2nd St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67509

CERTIFICATE OF DEATH.

162 D 67509

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 Cambridge St. 15- WARD)

2-FULL NAME

(a) RESIDENCE NO. 606 Cambridge St. 15- WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Frank A. Markley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Corla M. Markley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed SEP 13 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1922, to Sept 12, 1922, that I last saw her alive on Sept 12, 1922, and that death occurred, on the date stated above, at 11 A. M. The CAUSE OF DEATH* was as follows:

Coronary

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Atherosclerosis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Jones, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67510

CERTIFICATE OF DEATH.

3/ D 67510

1-PLACE OF DEATH

Municipal Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (City)

ST. 12 WARD)

2-FULL NAME

Garrett Stack

(a) RESIDENCE NO.

308 E. Lafayette Avenue

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

61 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Do not know

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

John Stack

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Ellen Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Wm. Reed

15

Filed

SEP 13 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9-10-1922

17

I HEREBY CERTIFY, That I attended deceased from

Sep. 1, 1922, to Sep. 10, 1922.

that last saw him alive on Sep. 10, 1922.

and that death occurred, on the date stated above, at 1:15 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Phlebotomy with effusion (Tuberculosis?) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Clyde Wheeler

M. D.

(Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cemetery

DATE OF BURIAL

9/13, 1922

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item entered should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67511

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4401 Ready Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ann Anthony

(a) RESIDENCE. No. 4401 Ready Ave ST.; WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 50 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Richmond County Va

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Ely Weeden

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Mrs M. E. Riblin 4401 Ready Ave (Groom)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 6, 1922, to Sept 11, 1922,

that I last saw her alive on Sept 11, 1922,

and that death occurred, on the date stated above, at 8:20 m.

The CAUSE OF DEATH* was as follows:

Cephaloplexy

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Clinical Exam

(Signed)

J. H. Whelan

M. D.

, 19

(Address)

8139 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Nonnie Cemetery Virginia

Sep 13 1922

20 UNDERTAKER

ADDRESS 1203

Henry Lutz

N. Broadway

MARGIN RESERVED FOR BINDING

Every item of information should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 Dolphin ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 134 Dolphin St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

1870, 1 (Month) (Day) (Year)

7-AGE,

52

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic 137
Housewife9-BIRTHPLACE,
(State or Country).

D.C.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP 13 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 10th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

March 20th 1921 to Sept 10th 1922

that I saw him alive on Sept 29th 1922

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia
Hemiplegia

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Lee Ellis M. D.

9/11/22, 1912 (Address) 924 York St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cemetery

DATE OF BURIAL

Sept. 13, 1922

20-UNDERTAKER

John H. Toddman

ADDRESS

142 N. Hill St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67513 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67513

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 32 N Bruce St., 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Augustus Randall

(Residence in Baltimore: No. 32 N Bruce St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, Colored 5-Single, Married, Widowed, or Divorced, Single

6-DATE OF BIRTH, June 15 1886 (Month) (Day) (Year)

7-AGE, 36 yrs. 2 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer (b) General nature of industry, business, or establishment in which employed (or employer), Contractor

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, James H Randall

11-BIRTHPLACE OF FATHER, (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Katie Johnson

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Bennett

(Address) 32 N Bruce St

15- SEP 13 1922

Filed, 1922, J. H. Wahn Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 10 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) About 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) James W. Keaton M. D. (Coroner.)

Sept 10 1922 (Address) 700 E Charles

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Sept 13 1922

20-EMERALD, ADDRESS, 344 Carey St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Rks.

67514

D 67514

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67514

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1801 Edmondson Ave 20 WARD)

2. FULL NAME

Isoula D. Bernardini

(a) RESIDENCE

1801 Edmondson ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joe Bernardini

6 DATE OF BIRTH (month, day, and year)

Jan 6 1865

7 AGE

Years

Month

Days

If LESS than 1 day, hrs. or min.

57 9 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

St. Louis Mo.

10 NAME OF FATHER

James

11 BIRTHPLACE OF FATHER (city or town) (State or country)

St. Louis Mo.

12 MAIDEN NAME OF MOTHER

Josephine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

St. Louis Mo.

14 Informant (Address)

Joe Bernardini 1801 Edmondson Ave

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 19 22

17 I HEREBY CERTIFY, That I attended deceased from

Mar 19 21 to Sept 12 19 22

that I last saw her alive on Aug 14 19 22

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Spur (2)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Secondary Anaemia

(duration) 1 yr. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of stools

(Signed) Dr. H. Pearce M. D.

19 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

Cathedral Ave

DATE OF BURIAL

9/14 1922

20 UNDERTAKER

Ernye A. Daley Talbot & Tugala

ADDRESS

MARGIN RESERVED FOR BINDING
N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67515

HEALTH DEPARTMENT—CITY OF BALTIMORE.

Lavicka

VD 67515

100-001

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 7 ST., 7 WARD)

2-FULL NAME

John Lavicka
901 N. Pnt.

(a) RESIDENCE NO.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (Write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

18 8 0

7 AGE

42

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md. Annapolis

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Bayview Hospital
Med. Bldg.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 11, 1922

17 I HEREBY CERTIFY, that deceased from Jan. 20, 1919, to Sept. 11, 1922

that I last saw him alive on

Sept. 11, 1922
8:30 p.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pneumo-Pneumonia (Terminal)

CONTRIBUTORY (duration) yrs. mos. ds.
Knots type (duration) yrs. mos. ds.
Knots type (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unk.

Did an operation precede death? 24 Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Clinical finding

(Signed)

9/11/1922

Address

Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer

DATE OF BURIAL

Sept. 11, 1922

20 UNDERTAKER

Fiskler Fiskler

ADDRESS

1739 Eager

D 67516 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67516

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Woodman ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Henry H Hackman

(Residence in Baltimore: No. _____

St.; 68 yrs., 4 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)

6-DATE OF BIRTH

April 27th, 1854
(Month) (Day) (Year)

7-AGE

68 yrs., 4 mos., 16 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Clabour
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Balto

10-NAME OF FATHER,

Blamond Hackman

11-BIRTHPLACE OF FATHER (State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Mary Barlage

13-BIRTHPLACE OF MOTHER (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Frank H. Haller

(Address).

1616 McHenry St.

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 11, 1922
(Month) (Day) (Year)

17-HEREBY CERTIFY, That I attended deceased from

Sept 1 - 1922, to Sept 11, 1922,that I saw him alive on Sept 10, 1922,and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
Stomach
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D.

(Address).....1176 Woodman St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Cemetery, Sept 14, 1922

20-UNDERTAKER

ADDRESS

Knell & Son, 1825 W. Pratt St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

M.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

S-P 131522

Permission is hereby granted to keep the
remains until Sept 15/22.
J. Franklin J. Thompson,
Com. of Health

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

21929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retreat* ST. *28th* WARD)2-FULL NAME *Daniel Higgins*(a) RESIDENCE NO. *Mount Hope Retreat*

(Usual place of abode)

Length of residence in city or town where death occurred *72* yrs. — mos. — ds.How long in U. S., if of foreign birth? *72* yrs. — mos. — ds.REGISTERED NO. *D-67317*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Resident

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 3rd* 1922

17 I HEREBY CERTIFY, That I attended deceased from *July 16th* 1921 to *Sept 3rd* 1922
that I last saw him alive on *Sept 2nd* 1922,
and that death occurred, on the date stated above, at *7.30 A.* m.
The CAUSE OF DEATH* was as follows:

Chr. Gen. Auritis

abs (duration) *3* yrs. *4* mos. — ds.
CONTRIBUTORY *Terminal Dementia*
(Secondary) *abs* (duration) *5* yrs. *0* mos. — ds.

18 Where was disease contracted *Baltimore*
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Frank J. Flannery, M. D.*

(Signed) *Sept 3rd* 1922 (Address) *Mount Hope Retreat*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *New Cathedral Cemetery* DATE OF BURIAL *Sept 14* 192220 UNDERTAKER *WORTH COMPANY* ADDRESS *108 W. NORTH*15 Filed *Sept 13-22* *J. E. Elmer* Registrar

PARENTS

10 NAME OF FATHER *John Higgins*11 BIRTHPLACE OF FATHER (city or town) *Balto*
(State or country) *md*12 MAIDEN NAME OF MOTHER *Amanda A. Peterson*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*
(State or country) *md*14 Informant *Records of Mount Hope Retreat*
(Address) *Mount Hope Retreat*

Information should be carefully supplied. AGE should be properly classified. Exact status of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 67518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *7th & Washington Boulevard* Ward) *75*

(If death occurred in hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

Richard Nickols(Residence in Baltimore: No. *7 Prince George & Laurel* apt.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-Single,

Married,

Widowed,

or Divorced,

(Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

43

yrs.

mos.

ds.

If LESS than 1 day,

hrs.

or

min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,

(State or Country),

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

(State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER,

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

Filed

1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 12

(Month)

(Day)

192*2*

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Investigation* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Investigation* find that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

*Electrocuted by live wire which trimming trees**Accident* (Duration) *Instant* yrs..... mos..... ds.

CONTRIBUTORY

(Secondary)

(Duration) yrs..... mos..... ds.

(Signed) *James M. Penland* M. D.

(Coroner.)

241 B. 192 B. (Address) 700 E. Chase

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

*Laurel Md**Sept 14* 19*22*

20-UNDEERTAKER

ADDRESS

*J. J. Toney Sons**1318 Brighton*

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

67519

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

67519

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3060 Stoddard

ST.: 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John L. Smith

(a) RESIDENCE. NO. 3060 Stoddard

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Wara Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

9

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Street Car Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

078

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

MD

10 NAME OF FATHER

J. H. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Ellen Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

Mrs J. L. Smith - 3060 Stoddard

15

Filed, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 30, 19 22, to Sept 11, 19 22

that I last saw him alive on Sept 10, 19 22

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Relapsing Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Laryngeal Tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard W. Jones, M. D.

(Address) 12, 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

Sept 13 22

20 UNDERTAKER

ADDRESS

Harry H. Witzke

1531 1/2 Lombard

SEP 13 1922

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

67520

HEALTH DEPARTMENT—CITY OF BALTIMORE

67520

CERTIFICATE OF DEATH.

31

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S Paterson Park WARD)

2. FULL NAME

John Holmes

(a) RESIDENCE NO.

430 S Paterson Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of Catherine Holmes (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 20 Months 11 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elevator Operator 073
(b) General nature of industry, business, or establishment in which employed (or employer) Railroad. B. & O.
(c) Name of employer Balt & Ohio R.R. Co.

9 BIRTHPLACE (city or town) (State or country)

Balt & Md

10 NAME OF FATHER John Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Louise Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14

Informant Louise Harrison (Address) 430 S Paterson Park

15

Sept 13 1922 92 9 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 7, 1922, to Sept 11, 1922, that I last saw him alive on Sept 11, 1922, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel S. Fisher, M. D.

, 19 (Address) 302 S Paterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

20 UNDERTAKER

Wendell Ryffel & Co.

DATE OF BURIAL

Sept 14 1922

ADDRESS

315 N

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

2-67522 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 232 S Ann

ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clement A. Zglinicki

(a) RESIDENCE NO. 232 S Ann
(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2 1918

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 3 11 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER Anthony Zglinicki

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Helen Pietrzykoski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Anthony Zglinicki
(Address) 232 S Ann

15 File Sept 13 22 J. E. Wehm Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17 - 1922, to Sept 11, 1922, that I last saw him alive on Sept 10, 1922, and that death occurred, on the date stated above, at 12 A. M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

CONTRIBUTORY (Secondary) General Exhaustion (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? usual (Signed) J. E. Wehm M. D.

19 (Address) 125 S. B. Way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Rosary

Sep 13 1922

20 UNDERTAKER

ADDRESS

JOHN M. WEBER

1803 BANK ST.

D 67523

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1311 N Monroe* ST. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *1311 N. Monroe* ST. *15* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Elsie Warfield

6 DATE OF BIRTH (month, day, and year)

7 AGE

34 Years*5* Months*18* Days

If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

Coal wagon

(c) Name of employer

E. S. Brady & Co

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Mr. T. Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Mrs. Elsie Warfield 1311 N. Monroe St

SEP 13 1922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 12 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Sept 11 1922* to *Sept 12 1922*that I last saw him alive on *Sept 12 1922*and that death occurred, on the date stated above, at *4:15 A.M.*

The CAUSE OF DEATH* was as follows:

Chrom. Endocarditis

CONTRIBUTORY (Secondary)

(duration) *Unknown* yrs. mos. ds.*acute Bronchitis*(duration) *6* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Chas. C. Conser*, M. D.*9/12 1922* (Address) *1101 N. F. Fulton A.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

George I. Q. Gibson

ADDRESS

713 4

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL: CREMATION OR RE-MOVAL

UNDERTAKER

DATE OF BURIAL

ADDRESS

D 67525

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67525

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 Monument St.,

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 219 Monument St.,

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX *M* 4-COLOR OR RACE *A* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *1851*
(Month) (Day) (Year)

7-AGE, *71* yrs., mos., ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Household*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto*

10-NAME OF FATHER, *Geo. H. Peters*

11-BIRTHPLACE OF FATHER (State or Country), *Balto*

12-MAIDEN NAME OF MOTHER *Ada Ruhl*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edna H. Peters*

(Address) *219 Monument*

15-

Filed *191* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 11, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr 10, 1922*, to *Sept 11, 1922*, that I saw him alive on *Sept 6, 1922*, and that death occurred, on the date stated above, at *12:25 A.M.*
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage with hemiplegia
(Duration) *5* yrs., *4* mos., *4* ds.

CONTRIBUTORY (Secondary) *arterio-sclerosis*
(Duration) *5* yrs., *4* mos., *4* ds.

(Signed) *Chas. J. Keller M. D.*
Sept. 12, 1922 (Address) *219 Monument*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *5* yrs., *4* mos., *4* ds. In the State *4* yrs., *4* mos., *4* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *9/14, 1922*

20-UNDERTAKER ADDRESS *J. J. Harty House 118 Light St.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

SEP 13 1922

D 67527

HEALTH DEPARTMENT—CITY OF BALTIMORE 67527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Lombard & Jones

ST. WARD)

2-FULL NAME

Helen Rosalyn Miller

(a) RESIDENCE. NO.

729 W. Baltimore

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female W.

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Albert Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Gertrude Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Albert Miller 729 W. Baltimore

Filed SEP 13 1922

19

MZA

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/12 1922

17

I HEREBY CERTIFY, That I attended deceased from

8/10 1922, to 9/12/1922,

that I last saw her alive on 9/12/22, 19

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Intoxication (acute) Gastro-intestinal indigestion

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

Inanition

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

clinical findings

(Signed)

Leon Gordon M.D.

19

(Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

Sept 14th 1922

20 UNDERTAKER

ADDRESS

Henry B. Ramminger

Schneider

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BUREAU OF RECORDS
N. B. — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. — I-10-21 — M&T — 1500 Bks.

HEALTH DEPARTMENT — CITY OF BALTIMORE
D 67528
CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1209 Wilcox ST., 10 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles L. Ague
(a) RESIDENCE NO. 1209 Wilcox ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? Life yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, ~~Married~~, Widowed, Single
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Aug 29 - 1922
7 AGE Years _____ Months _____ Days 14 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) _____ (State or country) _____
10 NAME OF FATHER Charles A. Ague
11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____
12 MAIDEN NAME OF MOTHER M. Lane
13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____

14 Informant Charles A. Ague
(Address) 1209 Wilcox St.

15 Robert P. Harrison
19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1922
17 HEREBY CERTIFY, That I attended deceased from Sept. 10, 1922 to Sept. 12, 1922, that I last saw him alive on Sept. 12, 1922, and that death occurred, on the date stated above, at 7:15 P. M.
The CAUSE OF DEATH* was as follows: Exhaustion

(duration) _____ yrs. _____ mos. 3 ds.
CONTRIBUTORY (Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____
Did an operation precede death? no Date of none
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) J. Lee Magness, M. D.
19 _____ (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St Vincent Cemetery
20 UNDERTAKER George J. Ruth
DATE OF BURIAL Sept. 13, 1922
ADDRESS 735 Hayford Ave.

SEP 13 1922

D 67529

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67529

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE, (No. 1712 Chilton Ave ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Jacob Bosch

(a) RESIDENCE NO.

1712 Chilton Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

67 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

67 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. Single, Married, Widowed, or Divorced, (write the word)

Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Hettie Bosch

6. DATE OF BIRTH (month, day, and year)

3/13/1854

7. AGE

68

Years

Months

Days

If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Police Officer

(b) General nature of industry, business, or establishment in which employed (or employer)

661

(c) Name of employer

9. BIRTHPLACE (city or town) (State or country)

Germany

10. NAME OF FATHER

George Bosch

11. BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12. MAIDEN NAME OF MOTHER

Anne Wyler

13. BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Hettie Bosch
1712 Chilton Ave.

15

By

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year) Sept 11 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 5 - 1922 to Sept 11 - 1922.

that I last saw him alive on Sept 11 - 1922.

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Coronal Hemorrhage

(duration)

yrs.

mos.

6 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

6 ds.

18. Where was disease contracted if not at place of death?

✓

Did an operation precede death?

no

Date of

✓

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

M. A. Brown

M. D.

19

(Address)

125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR RE-MOVAL

Greenmount Cemetery

DATE OF BURIAL

9/13 1922

20. UNDERTAKER

George J. Ruth

ADDRESS

1755 Hapgood Ave

MARGIN RESERVED FOR SIGNATURE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN should state NAME, ADDRESS, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 13 1922

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67530

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 E Preston ST., 10 WARD)

2. FULL NAME

Richard S. Jones

(a) RESIDENCE NO.

1405 E Preston

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Barbara L Jones

6 DATE OF BIRTH (month, day, and year) Aug. 11th 1853
7 AGE Years 69 Months 1 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) A. C. R. R. Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Md

10 NAME OF FATHER

Christopher Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Co Md

12 MAIDEN NAME OF MOTHER

Elizabeth Smardon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

England

14

Informant (Address)

Mrs Barbara L Jones
1405 E Preston St

15

Filed

Robert P. Harrison,

19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12 19 22

17 I HEREBY CERTIFY, That I attended deceased from Aug 26 19 22, to Sept 12 19 22, that I last saw him alive on Sept 12 19 22, and that death occurred, on the date stated above, at 345 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual clinical

(Signed) Edmond Macdonald M. D.

(Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Greenmount Cemetery DATE OF BURIAL Sept 14th 1922

20 UNDERTAKER George Schilling & Sons ADDRESS 1126 Edmonst

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 67531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Bayle ST. 24 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1510 Bayle ST. 24 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

. 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1922, to Sept 11, 1922, that I last saw him alive on Sept 11, 1922, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Address) 1644 Hancock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.-I-10-21-M&T-1500 Bks.

D 67532 HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST., *8* WARD)

2-FULL NAME

(a) RESIDENCE NO. *2135 Bayford Ave* ST., *8* WARD

(Usual place of abode) Length of residence in city or town where death occurred *35* yrs. mos. *6* ds. How long in U. S., if of foreign birth? *35* yrs. mos. *6* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 *Widowed* *Single, Married, Widowed, or Divorced, (write the word)*

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Late Arthur Bregel

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *54*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Ellen Crowsley
903 E. Hoffman St.

15

Filed

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 13 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 6 1922* to *Sept 13 1922*.

that I last saw him alive on *Sept 13 1922*

and that death occurred, on the date stated above, at *2:10 a.m.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Angina pectoris*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Sept 6/22*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *S. W. Kaurer* M. D.

, 19 (Address) *St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery *Sept. 15, 1922*

20 UNDERTAKER

ADDRESS

George F. Rutt *1235 Bayford Ave.*

D 67533

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67533

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Scott ST.: 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel A. Davidson(a) RESIDENCE. No. 1122 Scott ST.: 21 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18447 AGE Years 77 Months 4 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Thomas Davidson11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)12 MAIDEN NAME OF MOTHER Margaret Simpson13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)14 Informant Miss Davidson (Address) 1122 Scott St15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 19 2217 I HEREBY CERTIFY. That I attended deceased from Jan 3 19 22, to Sept 10 19 22, that I last saw him alive on Sept 10 19 22, and that death occurred, on the date stated above, at Home m. The CAUSE OF DEATH* was as follows:Progressive Pericarditis Chronic (duration) 3 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 2 mos. 1 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date of Sept 10Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. J. Harrison M. D.9/11, 1922 (Address) 517 Lomb St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

U.S. NATIONAL CEMETRY

9/14 1922

20 UNDERTAKER

ROBERT BROOKS SON

ADDRESS COR CALHOUN HOLLINS ST.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

SEP 13 1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67534

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Annapolis ST., 9 WARD)

2. FULL NAME

Rose Mary Webster

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
1630 Annapolis ST., 9 WARD
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 11, 22
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
1/2 day, 1 hr., 2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.10 NAME OF FATHER Lennox P. Webster11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Maryland12 MAIDEN NAME OF MOTHER Rose Mary Schrey13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14

Informant (Address)

Rose Mary Webster
1630 AnnapolisRobert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 192217 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1922 to Sept. 11, 1922
that I last saw him alive on Sept. 11, 1922
and that death occurred, on the date stated above, at 5:45 P.M.
The CAUSE OF DEATH* was as follows:atelectasis(duration) yrs. mos. 1/2 day

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? x-ray(Signed) Thos. F. Stevens, M. D.
9/11/22 (Address) 2878 Stanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health

DATE OF BURIAL

ADDRESS

SEP 13 1922

MARGIN RESERVE—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

SEP 13 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67535

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Home & Inf. 3rd East* ST. *WARD*)

2. FULL NAME

Baby Boy King

(a) RESIDENCE NO.

1200 Eastern Office

ST.

WARD

Balt., Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 12, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

James Dunlop King

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown, Texas

12 MAIDEN NAME OF MOTHER

Norothy Frances Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Wilmington, N.C.

14

Informant (Address)

Robert P. Harrison

19

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from *3:10 A.M. Sept. 12, 1922* to *3:20 A.M. Sept. 12, 1922*

that I last saw him alive on *Sept. 12, 1922*

and that death occurred, on the date stated above, at *3:20 A.M.*

The CAUSE OF DEATH* was as follows:

Miscarriage (6 mo.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Premature Separation of Placenta

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Delivery* Date of *Sept. 12, 1922*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Raymond P. Huetten* M.D.

19 (Address) *Church Home & Inf. 3rd East*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner of Health

ADDRESS

SEP 13 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67536

CERTIFICATE OF DEATH.

D 67536

1. PLACE OF DEATH

CITY OF BALTIMORE: (No University Hosp. ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Baby Boy Reed(a) RESIDENCE NO. University Hospital ST., 4 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) 9/11/22.

7 AGE Years Months Days If LESS than 1 day, 3 hrs. 47 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ 000(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9 BIRTHPLACE (city or town) Baltimore, Md (State or country)10 NAME OF FATHER George Reed11 BIRTHPLACE OF FATHER (city or town) St. Mary's Co. Md. (State or country)12 MAIDEN NAME OF MOTHER Cora Hall13 BIRTHPLACE OF MOTHER (city or town) Montgomery Co. Md. (State or country)

14 Informant (Address)

15 Filed 9/13/22

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12, 1922.17 I HEREBY CERTIFY, That I attended deceased from Sept 11, 1922 to Sept. 12, 1922, that I last saw him alive on Sept 12, 1922, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

PrematurityCONTRIBUTORY (Secondary) Prematurity. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? ✓What test confirmed diagnosis? ✓(Signed) Milton C. Lang, M. D., 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health,

SEP 13 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIAN should state exact statement of OCCASION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67537. HEALTH DEPARTMENT—CITY OF BALTIMORE **D 67537.**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. Joseph Hospital - V*

City of BALTIMORE: (No. *1823* St. *Alia Anna* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Peter Stasiewicz*

(Residence in Baltimore: No. *1823 Alia Anna* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-Single, Married, Widowed, or Divorced, (Write the word.) <i>Married</i>	16-DATE OF DEATH, <i>Sept. 11</i> , 19 <i>22</i> (Month) (Day) (Year)	
6-DATE OF BIRTH, <i>June 12</i> , 18 <i>74</i> (Month) (Day) (Year)			17- I HEREBY CERTIFY That I took charge of the remains described above, held an <i>Inquest</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>Inquest</i> and that said deceased came to <i>his</i> death (Inquest, autopsy or inquiry.) on the day stated above.	
7-AGE, <i>46 yrs. 2 mos. 24 ds.</i> If LESS than 1 day, hrs. or min.?			The CAUSE OF DEATH* was as follows: <i>Multiple Bowels (auto accident)</i> (Duration) yrs. mos. ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... (b) General nature of industry, business, or establishment in which employed (or employer)..... <i>Labor</i>			CONTRIBUTORY (Secondary) <i>Sticks</i> (Duration) yrs. mos. ds.	
9-BIRTHPLACE, (State or Country), <i>Poland</i>			(Signed) <i>Dr. Edmund Blados</i> (Coroner) <i>Sept 12 1922</i> (Address) <i>1437 E. Bay</i>	
PARENTS.	10-NAME OF FATHER, <i>Casimier Stasiewicz</i>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.		
	11-BIRTHPLACE OF FATHER, (State or Country), <i>Poland</i>	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.		
	12-MAIDEN NAME OF MOTHER, <i>unknown</i>	Where was disease contracted, if not at place of death?.....		
	13-BIRTHPLACE OF MOTHER, (State or Country), <i>Poland</i>	Former or usual residence.....		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Tekla Stasiewicz</i> (Address) <i>1823 Alia Anna</i>			19-PLACE OF BURIAL OR REMOVAL, <i>Holy Rosary</i> DATE OF BURIAL, <i>Sep 15</i> , 19 <i>22</i>	
15- Filed <i>Robert P. Harrison,</i> REGISTRAR. <i>1922</i>			20-EMERALD TAKER, <i>Lohn & Weber</i> ADDRESS <i>1803 Bank</i>	

Burial Permit 61822

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90D 67538

D 67538

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Home wood Apts. ST. 12 WARD)

2-FULL NAME

(a) RESIDENCE NO. Home wood Apts.

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 1 ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED Wholesale Retail Tobacco

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER Franklin B. Boucher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Japan

12 MAIDEN NAME OF MOTHER Anna B. Huchman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) Wm Boucher Jr.

15

SEP 14 1922

Registrar G. C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/11 1922

17 I HEREBY CERTIFY, That I attended deceased from 8/27, 1922, to 9/11, 1922, that I last saw him alive on 9/11, 1922, and that death occurred, on the date stated above, at 10:40 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) 2 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? no

What test confirmed diagnosis? yes (Signed) Dr. Stanley Corns (Address) 2900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL Rossine Cemetery

DATE OF BURIAL Sept 14 1922

20 UNDERTAKER George J. Smith

ADDRESS 808 N. 25th St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 S. Hanover ST.: 27 WARD)2-FULL NAME James F. Taylor(a) RESIDENCE: (No. 404 S. Hanover ST.: 27 WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Young Taylor6 DATE OF BIRTH (month, day, and year) Mar 28, 18657 AGE Years 57 Months 3 Days 14 If LESS than 1 day, hrs. or min.8 OCCUPATION OF DECEASED Laborer 040

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)10 NAME OF FATHER Jas. S. Taylor11 BIRTHPLACE OF FATHER (city or town) Va (State or country)12 MAIDEN NAME OF MOTHER Levina Taylor13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)14 Informant Ida Young Taylor (Address) 404 S. Hanover St.15 Filed SEP 14 1922Registrar George J. Smith

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 12 192217 I HEREBY CERTIFY, That I attended deceased from Apr. 19, 1922, to Sept 12, 1922, that I last saw him alive on Sept 12, 1922, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Carcinoma of rectumCONTRIBUTORY (Secondary) Hemorrhage, Carcinoma (duration) 7 yrs. 0 mos. 0 ds.Cochise Co (duration) 8 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? Place of deathDid an operation precede death? yes Date of Apr. 19, 1922Was there an autopsy? noWhat test confirmed diagnosis? X-ray clinical obs.(Signed) Edward J. Johnson, M. D., 19 (Address) 1212 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL Sept 15 192220 UNDERTAKER George J. Smith ADDRESS 1000 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67540

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Cor. Frederick and Hillman* St., *19* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Sarah E. Conner*

(Residence in Baltimore: No. *1616 Hollins* St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH *March 22 1880*
(Month) (Day) (Year)

7-AGE *42* yrs. *5* mos. *19* ds. If LESS than 1 day,hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Clerk*
(b) General nature of industry, business, or establishment in which employed (or employer) *Straw Hat Co*

9-BIRTHPLACE, (State or Country) *Gaithersburg*

10-NAME OF FATHER, *W. E. Conner*

11-BIRTHPLACE OF FATHER, (State or Country), *Maryland*

12-MAIDEN NAME OF MOTHER, *Miranda Brewster*

13-BIRTHPLACE OF MOTHER, (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edna Stedman*

(Address) *Shipley Heights Md*

15- Filed *SEP 14 1922* Registrar. *Q. J.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 11 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed Chest Fracture
lost leg + remainder by
automobile passing over the
body accident (Duration).....yrs.....mos.....ds.

CONTRIBUTORY *General Hemorrhage* (Secondary) (Duration).....yrs.....mos.....ds.

(Signed) *James M. Conner* M. D. (Coroner.)
Sept 12 1922 (Address) *700 E. Chasest*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? *Frederick Ave & Hillman St*

Former or usual residence *1616 Hollins St*

19-PLACE OF BURIAL OR REMOVAL, *Landon Park* DATE OF BURIAL, *Sept 15 1922*

20-UNDERTAKER, *George J. Smith* ADDRESS *1000 W. 11th St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67541

CERTIFICATE OF DEATH.

31 D 67541

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 E Pratt

ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Kamienski

(a) RESIDENCE NO. 2202 E Pratt

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 7 1909

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

12

11

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER Stanislaus Kamienski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Baderski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14

Informant Stanislaus Kamienski (Address) 2202 E Pratt St

15

Filed

SEP 14 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 11 1922

17 I HEREBY CERTIFY That I attended deceased from Sept 11, 1922 to Sept 11, 1922

that I last saw him alive on Sept 11, 1922

and that death occurred, on the date stated above, at 125 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration)

ys.

mos.

ds.

(duration)

ys.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed William J. Ryan, M. D. 1913 St. for 4 years

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Cross 20 UNDERTAKER

Balto County Sep 14 22

JOHN M. WEBER

1803 BANK ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67542

CERTIFICATE OF DEATH.

161 D 67542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 N. Pine

ST.; 17 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Johnson

(Residence in Baltimore: No. 505 N. Pine

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE. Colored
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH, July 29, 1922
(Month) (Day) (Year)

7-AGE, 13 yrs., 13 mos., 13 da.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country), Baltimore Md

10-NAME OF FATHER, James Johnson
11-BIRTHPLACE OF FATHER (State or Country), Md
12-MAIDEN NAME OF MOTHER, Florence Gantt
13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Juanita Buller

(Address) 505 N. Pine St

15-

Filed 191 M 79 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 11, 1922
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1922, to Sept 11, 1922, that I saw him alive on Sept 10, 1922, and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Morison
(Duration) yrs. 1 mos. 13 da.

CONTRIBUTORY (Secondary) Dist. (Duration) yrs. 1 mos. 13 da.

(Signed) N. Lee Spivey, M. D.
9/12, 1922 (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

W. E. Carter Co. Sept 14, 1922

20-UNDERTAKER, ADDRESS

N. Lee Spivey, P. A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

WARD

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

Filed

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1922, to Sept 13, 1922, that I last saw her alive on Sept 13, 1922, and that death occurred, on the date stated above, at 8:25 AM.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 14 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67544

113 D 67544

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4700 Donnell ST. 24 WARD)

2. FULL NAME

Lillian Webb

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

4700 Donnell ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. _____

How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single6a If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year)

June 12 1922

7 AGE

Years

Months

Days

If LESS than
1 day, _____ hrs.
or _____ min.31

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md.

10 NAME OF FATHER

Charles Webb11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto
Md.

12 MAIDEN NAME OF MOTHER

Eug. W. Grackler13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto
Md.

14

Informant
(Address)Charles Webb
4700 Donnell St.

15

Filed

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1922

17 I HEREBY CERTIFY, That I attended deceased from

9/7/22, 1922, to 9/13, 1922,that I last saw her alive on _____ 1922and that death occurred, on the date stated above, at 1042 A. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis(duration) _____ yrs. 2 mos. _____ ds.CONTRIBUTORY
(Secondary)Auto intoxication(duration) _____ yrs. 7 mos. _____ ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis?

(Signed) J. J. McGarrel, M. D.Address 633-5-3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Lawn Cemetery Sept 15 1922

20 UNDERTAKER

H. Vandewer & Son 1712 Thacker St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY STATE PHYSICIAN SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF CAUSE OF DEATH IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

141922

Burial Permit Clerk.

D 67545

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Harlem Av. ST., 16 WARD)2-FULL NAME Quincy V. Starr(a) RESIDENCE NO. 1404 Harlem Av. ST., 16 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2mos. 1

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE Wht5 Single, Married, Widowed,
or Divorced, (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 12/22

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)10 NAME OF FATHER Edwin Starr11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)12 MAIDEN NAME OF MOTHER Miss Sinclair13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)14 Informant Edwin Starr
(Address) 1404 Harlem Av.15 Filed Robert F. Harrison,

19

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1922

17

I HEREBY CERTIFY, That I attended deceased from
July 10, 1922 to Sept 13, 1922
that I last saw her alive on Sept 12, 1922
and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Prematurity 6 M 3 weeks -
Very small, weak, foetus
Always unable to swallow
no breast milk.(duration) yrs. 2 mos. ds.CONTRIBUTORY Sudden change in temperature
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) E. F. Harrison M. D.9/13, 1922 (Address) 1605 N. North Av.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

New Cathedral Cemetery Sept 14 1922

20 UNDERTAKER

ADDRESS

F. A. Krause & Son 737 HanoverN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67546

CERTIFICATE OF DEATH.

D 67546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2954 W. North Ave. St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jillie Reamer.(Residence in Baltimore: No. 2954 W. North Ave St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE, <u>white</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) <u>married</u>
-------------------------	----------------------------------	--

6-DATE OF BIRTH, unknown - 1
(Month) (Day) (Year)7-AGE, 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife - 1
(b) General nature of industry, business, or establishment in which employed (or employer) 0319-BIRTHPLACE, (State or Country), Russia.10-NAME OF FATHER, Hyman Jacobson11-BIRTHPLACE OF FATHER (State or Country), Russia.12-MAIDEN NAME OF MOTHER Mildred Levine.13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Jacobson(Address) 2954 W. North Ave15- Robert P. Harrison,

Filed, 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 13th, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 2nd 1922, to Sept. 12th 1922, that I saw her alive on Sept. 12th 1922, and that death occurred, on the date stated above, at 7 a m. The CAUSE OF DEATH* was as follows:Mitral Stenosis with Auricular Fibrillation(Duration) 5 yrs. mos. ds.CONTRIBUTORY Chronic IntestinalNephritis (Secondary) (Duration) 1 yrs. mos. ds.(Signed) J. C. Dickson M. D.Sept. 13, 1922. (Address) 3055 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring RunDATE OF BURIAL, Sept 13, 192220-UNDERTAKER May HermanADDRESS 127 EBaltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67547

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 158255 No 67547)

JOHNS HOPKINS HOSPITAL.

ST.,

WARD)

2-FULL NAME

Allen Hirschberger

(a) RESIDENCE NO.

Bedford Pa RDPs

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

7

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male white married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Rebecca Hirschberger

6 DATE OF BIRTH (month, day, and year)

Nov 23-1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa

10 NAME OF FATHER

Samuel Hirschberger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Anna Zimmers

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

544 N. Mulberry

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 6, 1922, to Sept 13, 1922,

that I last saw him alive on Sept 13, 1922,

and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH* was as follows:

Myasthenia Gravis resulting exhaustion.

(duration) / yrs. / mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Bedford, Pa

Did an operation precede death?

Yes Date of 9/9/22

Was there an autopsy?

Yes

What test confirmed diagnosis?

Case. Rebus

(Signed)

9/13 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Beesona Pa

Sept 16 1922

20 UNDERTAKER

ADDRESS

W M Routson

2238 N

North

SEP 14 1922

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of death should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67548

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

Lombard & Inner

ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

August William Weyel

(a) RESIDENCE. NO.

1123 Sexton St.

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

41 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

41 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Eleanora Weyel

6 DATE OF BIRTH (month, day, and year)

Mich 22 1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country)

Germany

10 NAME OF FATHER

Wm Weyel

11 BIRTHPLACE OF FATHER (city or town). (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Dora Brown

13 BIRTHPLACE OF MOTHER (city or town). (State or country)

Germany

14

Informant (Address)

Mrs. Eleanora Weyel
1123 Sexton St.

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/14

1922

17

I HEREBY CERTIFY, That I attended deceased from

9/9

1922, to

9/14

1922,

that I last saw him alive on

9/14

1922,

and that death occurred, on the date stated above, at 12.10 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 4 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Urna

(duration) yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical findings

(Signed) Dr. J. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park

DATE OF BURIAL

Sept 16 1922

20 UNDERTAKER

Wm Cook

ADDRESS

502 E North

SEP 14 1922

N. B. — WRITE PLAINLY, WITH UNFADING INK. — THIS IS A PERMANENT RECORD. PHYSICIANS should state cause of death in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

13-309
67549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 16-002
67549

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Richard Westerkam

(a) RESIDENCE NO.

949 Madison Ave

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 11 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Ferdinand Westerkam

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Emma Streichert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Denmark

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

Robert P. [unclear], 19

14 1922

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 13 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 8, 1922, to Sept 13, 1922, that I last saw him alive on Sept 13, 1922, and that death occurred, on the date stated above, at 5:50 P. M.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Trinity

20 UNDERTAKER

Wm Cook

DATE OF BURIAL

Sept 15 1922

ADDRESS

502 E North

D 67550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D 67550

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

4752 Pindico Road
ST. WARD)

2-FULL NAME

Kate Miller

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE, NO.

4752 Pindico Road
ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

George Miller

6 DATE OF BIRTH (month, day, and year)

Oct 21/59

7 AGE

63

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Geo Miller

30-E-Heath Street

15

Robert F. Harrison

19

Registrar

Burial Permit 6127

Fairmount - Potomac

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to Sept 13, 1922,

that I last saw him alive on Sept 13, 1922,

and that death occurred, on the date stated above, at 1125 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Orin, M. D.

Address 35 N. Potomac St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill

DATE OF BURIAL

Sept 16 1922

20 UNDERTAKER

William Cook

ADDRESS

5028 North

B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

SEP 14 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every death should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67551 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *442 E. Cross.* ST. *7th* WARD)

2. FULL NAME

(a) RESIDENCE NO. *442 E. Cross.* ST. *7th* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 26*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Westport Md.*

10 NAME OF FATHER *Wm. H. Sheckells*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balti. Md.*

12 MAIDEN NAME OF MOTHER *Anna Bayne*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balti.*

14

Informant (Address) *Anna Sheckells*

15

Filed *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 12 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 18*, 1922, to *Sept 12*, 1922,

that I last saw her alive on *Sept 12*, 1922,

and that death occurred, on the date stated above, at *10 P.* m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos. *28* ds.

CONTRIBUTORY (Secondary) *Spasms* (duration) yrs. mos. *9* ds.

18 Where was disease contracted if not at place of death? *yr*

Did an operation precede death? *yr* Date of *-*

Was there an autopsy? *yr*

What test confirmed diagnosis? *Stony B. Kollman*

(Signed) *Stony B. Kollman*, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Oluf's Cem *Sept 14, 1922*

20 UNDERTAKER ADDRESS

Margaret J. Flynn *1422 Bright St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67552

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 S. East Ave ST. 26 WARD)

2-FULL NAME

Annie R. Deal

(a) RESIDENCE NO.

5 S. East Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 10 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of None6 DATE OF BIRTH (month, day, and year) Oct. 16, 697 AGE Years 52 Months 10 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Mfg.(c) Name of employer Mr.9 BIRTHPLACE (city or town) (State or country) West Va.10 NAME OF FATHER Geo F. Deal11 BIRTHPLACE OF FATHER (city or town) (State or country) England12 MAIDEN NAME OF MOTHER Mary13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.14 Informant (Address) Mr. Martha J. Leighton
5 S. East Ave.15 Filed Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13, 192217 I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to Sept 13, 1922, that I last saw her alive on Sept 11, 1922, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma StomachCONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds. never complained of ill until the last illness

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 20, 22

Was there an autopsy?

What test confirmed diagnosis? Exploring op. and micro. ex. specimen(Signed) Dr. J. M. McLean, M. D.19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Loudon Bk. Cem. DATE OF BURIAL Sept 16, 192220 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EXACTLY. PHYSICIANS AND OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of OCCASION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
CITY OF BALTIMORE (NO. *10 Clark 3003*)
2-FULL NAME *George Alexander Leuz*
(Residence in Baltimore: No. *1619 Laurent St.*)

ST. *16* WARD)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*
6-DATE OF BIRTH, *Aug 9, 1880*
(Month) (Day) (Year)
7-AGE, *42* yrs., *1* mos., *5* ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Fireman*
(b) General nature of industry, business, or establishment in which employed (or employer). *City of Baltimore*

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER, *Chas. Leuz*
11-BIRTHPLACE OF FATHER (State or Country), *Balto.*
12-MAIDEN NAME OF MOTHER, *Louise Miller*
13-BIRTHPLACE OF MOTHER (State or Country), *Hagerstown C.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Agnes Leuz*
(Address) *1619 Laurent*

15-*Robert P. Harrison,*
1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 12, 1912*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fract skull -
Fract skull -
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) *W. M. Wiley* M. D.
(Coroner.)
Sept 13, 1912 (Address) *1639 Bway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents),
At place *Short White* In the of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Loudon Park Cemetery* DATE OF BURIAL, *9/14, 1912*

20-UNDERTAKER *Henry W. Mears & Son* ADDRESS *805 N. Calvert*

D 67554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67554

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4 WARD)

2-FULL NAME

William Johnson

(a) RESIDENCE NO.

Washington, Ga.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mamie Johnson

6 DATE OF BIRTH (month, day, and year)

61

Years

Months

Days

If LESS than 1 day, hrs. or min.

Sept 28 1861

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Book- accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Georgia

10 NAME OF FATHER

Josephus Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Georgia

12 MAIDEN NAME OF MOTHER

Emma Downing

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Georgia

14

Informant (Address)

Hospital

15

Robert P. Harrison,

is

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

4

WARD

How long in U. S., if of foreign birth?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 13 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1922, to Sept 13, 1922, that I last saw him alive on Sept 13, 1922, and that death occurred, on the date stated above, at 1:20 P m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia(duration) 1 yrs. 4 moa. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) yrs. moa. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Blood exam.(Signed) Daniel G. Pessagno, M. D., 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Washington, D. C.

UNDERTAKER

Thyella Taylor Fulton

DATE OF BURIAL

9/14

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS IMPORTANT. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

SEP 14 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 E. Larrake

ST.:

WARD)

2-FULL NAME

Thomas Donald Forckel

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1507 E. Larrake

ST.:

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 27 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 10, 1922, to Sept. 10, 1922,

that I last saw deceased alive on Sept. 10, 1922,

and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Intermittent Chorea

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Jones, M. D.

19 (Address) 1507 E. Larrake

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

N.E. Larrake

Sept. 15 1922

20 UNDERTAKER

ADDRESS

J. M. Cork

N.E. Larrake

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 14 1922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

67556

D 67556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin St. Hospital* St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *106 4 Carrollton Ave.* St.; yrs. *6* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

Dec 25

1890

(Month)

(Day)

(Year)

7-AGE,

52

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elinor Beth Lindh

(Address)

106 4 Carrollton Ave.

15-

Robert P. Harrison,

Filed

192

Barial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

13

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Investigation* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Investigation* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Hypert

CONTRIBUTORY (Secondary)

(Duration)

probly yrs. mos. ds.

(Signed) *James M. Kember* M. D. (Coroner.)

Sept 14 1922 Address *700 E. Chas St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)

At place of death *Franklin St. Hos* In the of death *106 4 Carrollton Ave* yrs. mos. ds. State *MD* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Landon Park

Sept 15 1922

20-UNDERTAKER,

ADDRESS *1000th*

George J. Smith

Forgett

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67557

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2112 E Biddle St. 8 WARD)

2. FULL NAME

(a) RESIDENCE NO. 2112 E Biddle

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

(or) WIFE of

Martin L Hoffacker

6 DATE OF BIRTH (month, day, and year)

Sept 15th 1847

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

11

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Conrad Turnbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Elizabeth Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Charles F Hoffacker 14210 Patterson Park Ave

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13th 1922

17 I HEREBY CERTIFY That I attended deceased from July 31, 1922, to Sept 12, 1922

that I last saw him alive on Sept 13, 1922

and that death occurred, on the date stated above, at 8:15 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary)

Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical signs

What test confirmed diagnosis? M. D.

(Signed) J. S. H. M. D.

Address 1307 N. Pat. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt Olivet Cemetery

DATE OF BURIAL

Sept 16th 1922

ADDRESS

20 UNDERTAKER

George Schilling & Sons 1126 E. Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

14 1922

Partial Permitt Clerk.

B. — Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 67559

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 D 67559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Prudential Oil Works,
City of BALTIMORE: (No. Curtis Bay. St. Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas O'Keefe.

(Residence in Baltimore: No. 1514 Covington St. 67 8 27 St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Widower. (Write the word.)

6-DATE OF BIRTH, December 17th, 1854. (Month) (Day) (Year)

7-AGE, 67 yrs., 8 mos., 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Watchman. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Andrew O'Keefe.

11-BIRTHPLACE OF FATHER, (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Johanna O'Tolle.

13-BIRTHPLACE OF MOTHER, (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen O'Keefe. (daughter)

(Address) 1514 Covington St.

15- Robert P. Harrison, Registrar.

Filed 14 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 13th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signature) Otto M. Reinhardt, M. D. (Coroner.)

Feb. 14th 1922 Address 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Oak Lawn Cem. Sept. 15, 1922

20-UNDERTAKER, ADDRESS

Gas B. Co. 1003 W. Balto St.

D 67560

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67560

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *U. P. 1 Hospital* St. *1* Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *George W. Belt*(Residence in Baltimore: No. *2840 Hudson St* St.; yrs. *82* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*6-DATE OF BIRTH, *about 1840* (Month) (Day) (Year)7-AGE, *82* yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Carpenter* (b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Balto Md*10-NAME OF FATHER, *George W. Belt*11-BIRTHPLACE OF FATHER, (State or Country), *Don't Know*12-MAIDEN NAME OF MOTHER, *Don't Know*13-BIRTHPLACE OF MOTHER, (State or Country), *Don't Know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Clara Shepler*(Address) *1902 Oak Hill Ave*

15-

Robert P. Harrison, 192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 13,* 192*2*, (Month) (Day) (Year)17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* find that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (accidental) (scuffling with) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. H. Hemmery* M. D. (Coroner.)Sept. 14, 1922 (Address) *2803 Edmond St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, *U. P. 1* yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

*4911 Cleveland Ave*Former or usual residence, *2840 Hudson St*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Oak Lawn Cemetery *Sept 16th 1922*

20-UNDERTAKER, ADDRESS

Wm Cook *502 E North*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67561

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hospital* ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John J. Bradshaw*(a) RESIDENCE. NO. *Summit Point W. Va* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *12* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White American* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Lula J. Bradshaw* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *April 7, 1867*7 AGE Years *55* Months *5* Days *7* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Ky.* (State or country)10 NAME OF FATHER *J. B. Bradshaw*11 BIRTHPLACE OF FATHER (city or town) *Ky.* (State or country)12 MAIDEN NAME OF MOTHER *Katherine Throckmorton*13 BIRTHPLACE OF MOTHER (city or town) *Va.* (State or country)14 Informant *Miss Lella Bradshaw* (Address) *Summit Point W. Va*15 Filed *G. G.* 19 *1922* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 14* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Sept. 9*, 19*22*, to *Sept 14*, 19*22*,that I last saw him alive on *Sept 14*, 19*22*,and that death occurred, on the date stated above, at *5:20 p.m.*

The CAUSE OF DEATH* was as follows:

Gastric ulcer

CONTRIBUTORY (Secondary)

(duration) *3* yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *Sept 11, 22*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. B. Puce*, M. D., 19 (Address) *Union Memorial Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Summit Point W. Va *Sept. 15 1922*

20 UNDERTAKER ADDRESS

George R. Schwab *2101 E. 4th Ave*

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67562

D 67562

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3908 North Charles St. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Elenor Kurtz
311 W. 95th. St.(a) RESIDENCE No. New York
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. - mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William K. Kurtz

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1868

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
54 6 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wycomico Co., Md.
(State or country)

10 NAME OF FATHER James Robertson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Wycomico Co. Md.

12 MAIDEN NAME OF MOTHER Mary Ellen Kelly

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Wycomico Co., Md.14 Informant Carl Robertson Kurtz
(Address) Colorado Bldg. Wash. D. C.

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1922, to Sept 13, 1922.

that I last saw him alive on Sept 13, 1922

and that death occurred, on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac
DilatationCONTRIBUTORY (Secondary) Chronic Hepatitis
(duration) yrs. mos. 1 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Buel M. D.

(Address) 2844 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park Cemetery 9/15/22 19

20 UNDERTAKER ADDRESS

Henry W. Mears & Son, 805 Calvert St

N. B.—WRITE PLAINLY, WITH CONFIDENCE. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-11 P. C. 1000 BRS.

D 67563
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67563

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 823 Aisquith ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Rubin

(a) RESIDENCE. NO. 823 Aisquith ST. WARD. (If nonresident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joshua Rubin

6 DATE OF BIRTH (month, day, and year)

7 AGE 70 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Joseph A. Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rubins 1114, 1922 Address 733 Aisquith ST

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis 1439 E. Baltimore

15 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14-22

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1922, to Sept 14, 1922 that I last saw him alive on Sept 14, 1922 and that death occurred, on the date stated above, at 7:30 p.m.
The CAUSE OF DEATH* was as follows:

Ch. Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Ch. Myocarditis (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hornstein, M. D.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67564

CERTIFICATE OF DEATH.

164 67564

1-PLACE OF DEATH

2337 Edmondson Ave

ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME

Mary Adeline Tifer

(a) RESIDENCE. NO.

2337 Edmondson St

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

all her life

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm Thomas Tifer

6 DATE OF BIRTH (month, day, and year)

7 AGE 76

Years 10 Months

24 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

no occupation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Mary Thayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant (Address)

Mrs Morris Robinson 2337 Edmondson Ave

15 Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9th 13th 1922

17

I HEREBY CERTIFY That I attended deceased from

For 35 years at different times

that I last saw her alive on Sept 13th 1922

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Old age

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Amanda T. Morris M. D.

, 19 (Address) 110 E. 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

David Ridge

Sept. 16 1922

20 UNDERTAKER

ADDRESS

George J. Smith

5000 20th St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

SEP 15 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67565

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)2-FULL NAME Delilah Johnson(a) RESIDENCE NO. Unknown ST. _____ WARD _____(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND OF
Raymond Johnson6 DATE OF BIRTH (month, day, and year) 18927 AGE Years Months Days If LESS than 1 day, hrs. or min.
30 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER John Scott11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia12 MAIDEN NAME OF MOTHER Sarah Ayres13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia14 Informant Hospital Records,
(Address) Municipal Hospital.15 Filed _____, 19 _____ Registrar [Signature]

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

76

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D 67565

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67566

CERTIFICATE OF DEATH

D 67566

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. *36 W Preston* ST. *17*)

WARD

FULL NAME *Jacob Hooper*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *561 W Preston St*)

Sr. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX *M* 4-COLOR OR RACE *Colored* 5-SINGLE, MARRIED, WIDOWED OR DIVORCED *Married* (Write the word)

6-DATE OF BIRTH *July 6, 1879* (Month) (Day) (Year)

7-AGE *43* yrs. *2* mos. *6* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer) *040*

9-BIRTHPLACE (State or country) *Baltr.*

10-NAME OF FATHER *Ezekiel Hooper*

11-BIRTHPLACE OF FATHER (State or country) *Baltr.*

12-MAIDEN NAME OF MOTHER *Anna W. Carey*

13-BIRTHPLACE OF MOTHER (State or country) *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Lula Hooper*

(Address) *561 W Preston St*

15 SEP 15 1922

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH *Sept. 12, 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 8, 1922* to *Sept 12, 1922*

that I saw him alive on *Sept 12, 1922*

and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation - general anasarca

(Duration) yrs. mos. ds. *40*

Contributory (SECONDARY) *Endocarditis, valvular insufficiency?*

(Duration) yrs. mos. ds. *10*

(Signed) *Harry P. McCarty* M. D. *Sept 12, 1922* (Address) *37 W. Preston St*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

My Auburn Cem *Sept 15, 1922*

20-UNDERTAKER

ADDRESS

Samuel Newby *Baltimore*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 4 WARD)2-FULL NAME Warren Dougherty

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 921 W. Baltimore, Md. ST. 7 WARD 2

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced, HUSBAND of none (or) WIFE of Mamie T. Dougherty6 DATE OF BIRTH (month, day, and year) 1879 June 297 AGE Years 43 Months Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Isaac Dougherty11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Martha Dougherty13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records (Address) M.T.H.15 SEP 15 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 192217 I HEREBY CERTIFY, That I attended deceased from April 26, 19 22, to Sept. 14, 19 22.that I last saw him alive on Sept. 14, 19 22.and that death occurred, on the date stated above, at 5.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 1 yrs. mos. ds.CONTRIBUTORY Tuberculous laryngitis (Secondary)(duration) 5 yrs. mos. ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? in sputum, X-ray(Signed) Francis L. Boley, M. D.9-14-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Menns and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER Commissioner Health

ADDRESS

230 WGreene

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67568 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67568

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Laurens ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Elizabeth Woodley

(a) RESIDENCE NO. 1729 Laurens ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

F White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 26 1895

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

27 4 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home book 000

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ba

10 NAME OF FATHER

Mr. Krumm

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Mr. Krumm

12 MAIDEN NAME OF MOTHER

Mr. Krumm

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Mr. Krumm

14 Informant John T. Weisman (Address) 1729 Laurens

15 SEP 15 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1921, to Sept 14, 1922

that I last saw him alive on Sept 18, 1922

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

CONTRIBUTORY (Secondary) (duration) 1 yrs. mos. ds. Expansion

(duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemically

(Signed) R. C. Campbell, M. D.

19 22 (Address) 1644 Danvers St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn Cemetery

20 UNDERTAKER

W. M. Roston

DATE OF BURIAL

Sept 15 1922

ADDRESS

2235 N

North

D 67571

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67571

CERTIFICATE OF DEATH.

31

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1623 E Eager* ST., *7* WARD)2. FULL NAME *Ellen E. Beran*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *1623 E Eager*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. *1* mos. *19* ds. How long in U. S., if of foreign birth? *Sept* mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

*Berard J. Beran*6 DATE OF BIRTH (month, day, and year) *July 25, 1904*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
18 *1* *19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balls

10 NAME OF FATHER

George G. Bruntine

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balls

12 MAIDEN NAME OF MOTHER

Ellen M. Blocker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balls

14

Informant (Address)

Mr. Berard J. Beran
1623 E Eager

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 14, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

April 7, 1922, 19 *Sept 14, 1922*that I last saw him alive on *Sept 11, 1922*and that death occurred, on the date stated above, at *10:45* a. m.

The CAUSE OF DEATH* was as follows:

Primary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery *Sept 18, 1922*

20 UNDERTAKER

ADDRESS

Henry Horck Sur *1301 E Eager*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

EP 15 1922

D 67572

HEALTH DEPARTMENT—CITY OF BALTIMORE

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *8* Ward)

2-FULL NAME

(Residence in Baltimore: No. *1929 Patterson Place* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-Single,
Married,
Widowed,
or Divorced,
(Write the word.)
Single

6-DATE OF BIRTH

January 17, 18*77*
(Month) (Day) (Year)

7-AGE

47 yrs. *7* mos. *17* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

*Librarian*9-BIRTHPLACE,
(State or Country).*Balt md*

PARENTS.

10-NAME OF FATHER

Gas P. Hooker

11-BIRTHPLACE OF FATHER

(State or Country).

Balt md

12-MAIDEN NAME OF MOTHER

Adeline Russell

13-BIRTHPLACE OF MOTHER

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Anne Hartman

(Address)

1909 Patterson Place

15-

Filed, 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 14, 192*2*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry* find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Accidental - horse-drawn vehicle overturned
Fractures Skull - Cerebral Hemorrhage
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)(Signed) *J. S. Allen* M. D.
(Coroner.)
9-10-1922 (Address) *508 E Mt a*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery *Sept 16*, 1922

20-UNDERTAKER

ADDRESS

Henry Hooker & Son *1301 E Eager*

SEP 15 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13-8404

D 67573

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 9 WARD)

2. FULL NAME

Charles Rohrman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

Charles + Joppa Rd. ST. 9 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Baby food

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

George Rohrman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Margaret?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Date

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 13 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept 13, 19 22, to Sept 13, 19 22, that I last saw him alive on Sept 13, 19 22, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration)

yrs.

mos.

7 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) Horton Caspary, M. D.

19

(Address)

Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAN

20 UNDERTAKER

ADDRESS

Baltimore Cemetery Sept 16 19 22Henry Brock & Son 1361 E. Eager

Physicians should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

EP 15 1922

IMORE 67574
REGISTERED NO.

067574
PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	18	—	12	

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) **Name of employer**

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town
(State or country)

14

Informant
(Address)

19

filed

Registrar

16 DATE OF DEATH (month, day, and year) July 14 1977

17 I HEREBY CERTIFY, That I attended deceased from
 _____, 19____, to _____, 19____
 that I last saw him alive on _____, 19____

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 10 d

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis

(Signed)

19-2 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 E. Madison ST., 7 WARD)2. FULL NAME Doncetta Guarino(a) RESIDENCE No. 1724 E. Madison ST., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? 25 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND or (or) WIFE of Anthony Guarino6 DATE OF BIRTH (month, day, and year) Not known7 AGE Years 57 Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Italy (State or country)10 NAME OF FATHER Henry Russo11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)12 MAIDEN NAME OF MOTHER Grace Guarino13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)14 Informant M. Anthony Guarino (Address) 1724 E. Madison St.15 Filed EP 15 1927, 19 — Registrar Henry Horchler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14, 19 2217 I HEREBY CERTIFY, That I attended deceased from Sept 10, 19 22 to Sept 14, 19 22.that I last saw her alive on Sept 14, 19 22, and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Vascular Disease

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [Signature], M. D.19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer Cemetery DATE OF BURIAL Sept. 18, 19 2220 UNDERTAKER Henry Horchler ADDRESS 1301 E. Eager

N. B.—WRITE PLAINLY, WITH CORRECTION. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67576

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N Patterson Park Ave ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 22 N Patterson Park Ave, St.: 2 yrs., 5 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

(Month) May, (Day) 12, (Year) 1922

7-AGE,

2 yrs., 5 mos., 5 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE, (State or Country),

Balt Md

10-NAME OF FATHER,

Louis Bender

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Anna Suck

13-BIRTHPLACE OF MOTHER (State or Country),

Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Louis Bender

(Address)

22 N Patterson Park Ave

15-

Filed 5/19/22

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) Sept, (Day) 15, (Year) 192217- I HEREBY CERTIFY, That I attended deceased from May 12 1922, to Sept 15 1922, that I saw her alive on Sept 14 1922,and that death occurred, on the date stated above, at 6:4 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho

(Duration) yrs. mos. ds. 2 ds.

CONTRIBUTORY (Secondary)

Cerebral Tumor

(Duration) yrs. mos. ds. 5 mos.

(Signed)

C. Loring Foster, M. D.

Sept 15, 1922 (Address) 1017 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baker Rosedale

DATE OF BURIAL,

Sept 15, 1922

20-UNDERTAKER,

Max Johnson

ADDRESS

127 E

Balt St

Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67577

HEALTH DEPARTMENT—CITY OF BALTIMORE

67577

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4004 Belview Ave ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth J. Carnack(a) RESIDENCE. NO. 4004 Belview Ave ST. 15 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Coast J. Carnack6 DATE OF BIRTH (month, day, and year) Sept 20 18907 AGE Years 71 Months 11 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Thurmont (State or country) md10 NAME OF FATHER John Ross Witherow11 BIRTHPLACE OF FATHER (city or town) md (State or country)12 MAIDEN NAME OF MOTHER Mary Ann Hoy13 BIRTHPLACE OF MOTHER (city or town) md (State or country)14 Informant Ross F. Witherow (Address) 4004 Belview Ave15 Filed SEP 15 1922 19 H.A.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 13, 19 2217 I HEREBY CERTIFY, That I attended deceased from August 2, 1922, to September 13, 1922, that I last saw her alive on September 13, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

neuropathic interstitialis(duration) yrs. mos. 4 ds.CONTRIBUTORY (Secondary) myocarditis(duration) yrs. mos. 12 ds.18 Where was disease contracted is if not at place of death? isDid an operation precede death? no Date of isWas there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. A. Mayer, M. D., 19 (Address) 2438 Eustace Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thurmont Md DATE OF BURIAL Sept 16 192220 UNDERTAKER Chas. G. Black ADDRESS 742 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67578

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67578

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maryland General Hosp.* ST. *11* WARD)

2-FULL NAME

(a) RESIDENCE, No. *Savage, Md.* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

12

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male.

4 COLOR OR RACE

white.

5 Single, Married, Widowed, or Divorced, (write the word)

single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

Sept 10 1911

7 AGE

Years

11

Months

0

Days

5

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Daniel H. H. H.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Daisy Holmes.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Record

15

Filed

SEP 15 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 3 1922 to *Sept 15 1922*that I last saw him alive on *Sept 14 1922*and that death occurred, on the date stated above, at *4:25 A.M.*

The CAUSE OF DEATH* was as follows:

*Osteomyelitis Rt. femur.
Sf metatarsal bones.*(duration) yrs. *1* mos. *1* ds.

CONTRIBUTORY

(Secondary)

Staphylococcus aureus

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death?

*Yes.*Date of *9/10/22*

Was there an autopsy?

No.

What test confirmed diagnosis?

Clinical, laboratory.

(Signed)

Chas. Wilbur Stewart.

M. D.

9/15, 1922

(Address) *1738 E. 28th St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF INTERMENT OR REMOVAL

Funeral Home

DATE OF BURIAL

9-15 1922

20 UNDERTAKER

Ed B. Hark 115 E. West St.

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. 1021 Cathedral St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Otto Krochinsky

(Residence in Baltimore: No. 1021 Cathedral St. 7 yrs., 3 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

CORONER'S CERTIFICATE OF DEATH.

3-SEX male 4-COLOR OR RACE White 5-Single, Married, Widowed, or Divorced. Single

16-DATE OF DEATH September 14 1922
(Month) (Day) (Year)

6-DATE OF BIRTH June 13 1920
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

7-AGE 2 yrs. 3 mos. 1 ds. If LESS than 1 day, hrs. or min.?

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

8-OCCUPATION: (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer)

The CAUSE OF DEATH* was as follows:
Burns - as a result of
fire in bath tub
1 week (Duration) yrs. mos. ds.

9-BIRTHPLACE, (State or Country) Baltimore Md.

CONTRIBUTORY (Secondary) White (Duration) yrs. mos. ds. (Signed) M. D.

10-NAME OF FATHER Martin Krochinsky

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER Anna Smith

13-BIRTHPLACE OF MOTHER, (State or Country) Russia

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martin Krochinsky
(Address) 1021 Cathedral St

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

15- SEP 15 1922 1922 Registrar.

19-PLACE OF BURIAL OR REMOVAL, St Pauls (Violetville) DATE OF BURIAL, 9 - 15 1922

20-UNDERTAKER, Mrs Chas A & Rohde ADDRESS 600 Marlinton Ave

11- Every item of information should be carefully supplied. state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67580

D 67580

1-PLACE OF DEATH

CITY OF BALTIMORE: (Municipal Tuberculosis Hospital) WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boleslaw Sosnoski

(a) RESIDENCE NO. 608 S. Broadway

(Usual place of abode) Length of residence in city or town where death occurred Unknown yrs. mos.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Can Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Lawrence Sosnoski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Julia Kravieski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records (Address) M. T. H.

15 SEP 15 1922 Registrar H. A. M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1922, to Sept. 13, 1922.

that I last saw him alive on Sept. 13, 1922.

and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? B. in sputum, X-ray

(Signed) Francis L. Paleglicco, M. D.

9-13-22 (Address) Municipal Tub. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

16 1922

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank

PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67581

HEALTH DEPARTMENT—CITY OF BALTIMORE, D 67581

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

Registered No. C.....

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

SEP 15 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, Autopsy or Inquiry.)thereon and from the evidence obtained by said.....
(Inquest, au-

topsy or inquiry.) and that said deceased came to the death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. J. Hennessy M. D.

(Coroner.)

Sept. 14, 1922. (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. mos. ds. State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

2441 Macs St.

Former or usual residence. 2441 Macs St.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

20-UNDERTAKER,

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67583

HEALTH DEPARTMENT—CITY OF BALTIMORE

67583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 939 Montpelier St. St. 9 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Jacob M. Schillinger.

74 ---- 1
St.; yrs., mos. ds.)

(Residence in Baltimore: No. 939 Montpelier St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Widower (Write the word.)

6-DATE OF BIRTH, September 12th, 1848, 1 (Month) (Day) (Year)

7-AGE, 74 yrs. --- mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Tailor. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Paul Schillinger.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Margaret.

13-BIRTHPLACE OF MOTHER, (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Margaret Hecht, (daughter)

(Address), 939 Montpelier St.

15.

SEP 15 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September, 13th, 1922, 192 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Sept. 14th, 1922 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

D 67584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE—No.

ST.

WARD

2-FULL NAME

Mary Requer

(a) RESIDENCE NO.

232 Collins

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

April 23 1843

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79

4

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Servant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Kuberson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

Mulligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14

Informant (Address)

Bay View Hospital, Baltimore, Md.

15

File

SEP 15 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 30, 1922 to Sept. 13, 1922

that I last saw him alive on Sept. 13, 1922

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Pneumo-pneumonia (terminalis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dementia and Delirium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. J. Fordsmith M.D.

9/13/1922 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

DATE OF BURIAL

20 UNDERTAKER

J. S. Hippert 2256 E. 1st Ave

ADDRESS

SEP 15 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67585

113 D 67585

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1203 James St.* ST.: *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Margherita Spinnichia*(a) RESIDENCE. No. *1203 James* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Jan. 4-1922*

7 AGE

Years

8

Months

10

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto. City*10 NAME OF FATHER *Alfis Spinnichia*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *Michela Forte*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

14

Informant *Alfis Spinnichia*(Address) *1203 James St.*

15

Filed *SEP 15 1922**10*Registrar *G. L.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sep. 14th 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Sep. 10th 1922* to *Sep. 13th 1922*that I last saw her alive on *Sep. 13th 1922* at *4:30 a.m.*and that death occurred, on the date stated above, at *4:30 a.m.*

The CAUSE OF DEATH* was as follows:

acute diarrhoea(duration) yrs. mos. ds. *4*

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at place of death*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Charles Festa* M. D.(Signed) *Charles Festa* M. D., 19 (Address) *210 Pearl St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*Holy Redeemer Cemetery*DATE OF BURIAL *9/15 1922*

20 UNDERTAKER

*George J. Ruth*ADDRESS *1135 Hayford Ave.*

N. B.—WRITE CAREFULLY. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67586

CERTIFICATE OF DEATH.

D 67586

1-PLACE OF DEATH

City of BALTIMORE: (No. *U. P. D.* St. *9* Ward)

2-FULL NAME

(Residence in Baltimore: No. *1301 E. Lafayette* St.; yrs. *54* mos. *54* ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, *Married*, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Carpenter*
(b) General nature of industry, business, or establishment in which employed (or employer). *O/S*

9-BIRTHPLACE

(State or Country). *Baltimore Md.*

10-NAME OF FATHER, *Benjamin Cloud*

11-BIRTHPLACE OF FATHER

(State or Country). *Balto Md.*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER

(State or Country). *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elizabeth Cloud*

(Address) *1301 E. Lafayette Ave.*

15-

Filed

SEP 15 1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept. 12, 192*2*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*

(Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said *inquiry*

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (accident)

(Duration) yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. *1* mos. *1* ds.

(Signed) *J. E. Hennessy*

(Coroner.)

Sept 14, 192*2*

(Address) *202 E. Lexington*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place

In the

of death. yrs. *54* mos. *54* ds.

State. yrs. *54* mos. *54* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parkwood Cemetery

9/16, 192*2*

20-UNDERTAKER

ADDRESS

George J. Ruth

1735 Hanford

D 67587

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH US. Veterans' Hosp. #56

CITY OF BALTIMORE: (No. Fort McHenry Md. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gregoria Bergara

(a) RESIDENCE NO. US. Veterans' Hosp. #56 ST. WARD

(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 22 yrs. Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philippines
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant Hospital Records.
(Address) Fort McHenry Md.15 Robert P. Harrison,
Siled 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27, 19 22

17 I HEREBY CERTIFY, That I attended deceased from March 15, 19 22, to August 27, 19 22, that I last saw him live on August 27, 19 22, and that death occurred, on the date stated above, at 5:06 A. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Chronic Pulmonary
far advanced active.

(duration) yrs. mos. ds.

CONTRIBUTORY Nephritis, chronic parenchymatous.
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinic report.

(Signed) H.D. Luse, Surgeon (R) M.D.

(Address) 8/27/22 19 US.V. Hosp. #56 Ft. McHenry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Miac Curto P. 8/27/22 19 22
20 UNDERTAKER Jol. Linscott & Co., E. Balt.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be properly classified. Exact statement of OCCASION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Burial Permit Clerk

D 67588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Bank

ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1216 BK

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 14-22

7 AGE

Years

Months

Days

Sept 14 12 22

If LESS than 1 day, 0 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bldg

10 NAME OF FATHER

John Matarsen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Anna apt 22

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

John Felter

1216 BK Bank St

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 14, 1922, to Sept 15, 1922, that I last saw him live on Sept 15, 1922,

and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Congenital Weakness

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Venturi, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Vincent

Sep 15-1922

378 Ave

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

SEP 15 1922

[illegible]

D 67589

HEALTH DEPARTMENT—CITY OF BALTIMORE *✓ cm* 67589

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *1121* *Waverly Hospital* St. *4* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Kraters

(Residence in Baltimore: No. Elkridge No 1 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>Cake</i>	5-Single, Married, <i>Single</i> Widowed, or Divorced, (Write the word.)
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6-DATE OF BIRTH. 1942 (Write the words)
1942
 (Month) (Day) (Year)

7-AGE. 8 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER, James H. Baker

11-BIRTHPLACE
OF FATHER.
(State or Country).

12-MAIDEN NAME
OF MOTHER, *Don't Know*

13-BIRTHPLACE
OF MOTHER.
(State or Country). *U S A*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Waters

(Address) Elbridge, Md.

13-
Filed Robert P. Harrison,
5 1922 Registrar.

~~Burial Permit Clerk.~~

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 14 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held on
 (Inquest, autopsy or inquiry.)
 thereon and from the evidence obtained by said
 (Inquest, autopsy or inquiry.) and that said deceased came to death
 (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

fractured wound in chest

CONTRIBUTORY (Secondary) *Subj. to above supply*
(Duration) yrs. mos. ds. *Continuous*
(Duration) yrs. mos. ds. *Occasionally*

(Signed) W. J. [Signature] M. D. [Signature]
(Coroner.)
9-15 1922 (Address) 117 1/2 Sangford

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....	yrs.....	mos.....	ds.	In the State.....	yrs.....	mos.....	ds.
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Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
221 1 8-11	8-11

Elkridge Md.	Sat. 16, 1922
20-UNDERTAKER.	ADDRESS

Filed 5 1922

D 67590

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67590

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John Smith(a) RESIDENCE NO. 1021 Wilcox st.(Usual place of abode) ST. 10 WARD 10
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18867 AGE Years Months Days If LESS than 1 day, hrs. or min.
36

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler maker(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Illinois10 NAME OF FATHER Pete Smith11 BIRTHPLACE OF FATHER (city or town) (State or country) Canada12 MAIDEN NAME OF MOTHER Katie ??13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant (Address) Hospital Records15 ROBERT P. HARRISON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10, 19 2217 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 19 21 to Sept. 10, 19 22, that I last saw him alive on Sept. 10, 19 22, and that death occurred, on the date stated above, at 8.15 a. m.
The CAUSE OF DEATH* was as follows:Pulmonary tuberculosis(duration) 1 yrs. 7 mos. ds.CONTRIBUTORY Depressive psychosis
(Secondary) (duration) yrs. mos. ds. 1418 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis T.B. Sputum, X-ray(Signed) Francis P. Delaney, M.D.9-10-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL UNIVERSITY OF MARYLAND

20 UNDERTAKER

DATE OF BURIAL

SEP 14 1922

ADDRESS

B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

SEP 15 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67591

D 67591

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 3 WARD)2-FULL NAME Dora Paxter(a) RESIDENCE No. 1005 Brood Alley

(Usual place of abode)

ST. 3 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 19017 AGE Years Months Days If LESS than t day, hrs. or min. 21 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records, (Address) Municipal Hospital.15 Robert F. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 19 2217 I HEREBY CERTIFY, That I attended deceased from August 8, 19 22, to September 10 19 22.that I last saw her alive on September 10, 19 22.and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral TuberculosisCONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. ds. ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of 20

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. M. Sherrill, M. D.9/11/22 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

SEP 14 1922

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67592 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67592
CERTIFICATE OF DEATH.

PLACE OF DEATH
CITY OF BALTIMORE (No. *Hilton & Edmonson apt 45*) ST.: *45* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
FULL NAME *Robert L. Lewellyn Gressitt*
(Residence in Baltimore: No. *2837 N. North Ave* St.: yrs., mos. *16* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Male</i>	4-COLOR OR RACE. <i>White</i>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <i>Married</i> (Write the word.)
6-DATE OF BIRTH. <i>Sept 1, 1864</i> (Month) (Day) (Year)		
7-AGE. <i>58</i> yrs. <i>0</i> mos. <i>13</i> ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>U.S. Navy Paymaster</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country). <i>Vermont</i>		
PARENTS.	10-NAME OF FATHER. <i>Miner B. Gressitt</i>	
	11-BIRTHPLACE OF FATHER (State or Country). <i>England</i>	
	12-MAIDEN NAME OF MOTHER <i>May A. Mues</i>	
	13-BIRTHPLACE OF MOTHER (State or Country). <i>Vermont</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Robert P. Harrison*
(Address) *2837 N. North Ave*

15-
Filed *Robert P. Harrison* 191 *Sept 16*
Registrar. *Robert P. Harrison*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.
Sept 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Carcinoma of throat started on larynx spread to nasopharynx
(Duration) *10* yrs. *10* mos. *10* ds.
CONTRIBUTORY *Neuralgia from same* (Secondary) (Duration) *2* yrs. *10* mos. *10* ds.
(Signed) *James M. Wilson* M. D. (Coroner.)
2416 1912 (Address) *2001 Charles*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place In the
of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.
Woodlawn Cem *Sept 16, 1922*
20-UNDERTAKER, ADDRESS.
W. J. Tucker *N. V. Pa*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67593

D 67593

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 James St. WARD 21)

2-FULL NAME

Audrey Gruber

(a) RESIDENCE NO.

1200 James St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)FemaleWhiteSingle5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 15/22

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.40

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of worknone(b) General nature of industry,
business, or establishment in
which employed (or employer)job

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

Joseph Gruber11 BIRTHPLACE OF FATHER (city or town)
(State or country)Baltimore

12 MAIDEN NAME OF MOTHER

Edith Kinsley13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore

14

Informant
(Address)Miss Edith Gruber
1200 James St.

15

Filed

Robert P. Harrison,

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/15 19 22

17

HEREBY CERTIFY, That I attended deceased from

Sept 10, 1922, to Sept 15, 1922.that I last saw him alive on Sept 14, 1922.and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA

St. MatthewsSept 16, 1922

20 UNDERTAKER

ADDRESS

W. J. Tuckers SonsN.Y.C.

Physicians should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

P 15 1922

Bureau of Health

D 67594 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H9D 67594

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 N. Mulberry St. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. (No. 536 N. Mulberry ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 56 M 4 COLOR OR RACE cal 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Melvina Wells

6 DATE OF BIRTH (month, day, and year)

7 AGE 56 years — Months — Days If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer 57

(b) General nature of industry, business, or establishment in which employed (or employer)

Plasterer

(c) Name of employer

Albert Johnson

9 BIRTHPLACE (city or town) (State or country)

Canton, Ohio

10 NAME OF FATHER

Bud Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Canton, Ohio

12 MAIDEN NAME OF MOTHER

Rosetta Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Canton, Ohio

PARENTS

14 Informant (Address)

Melvina Wells
536 N. Mulberry St.

15

SEP 16 1922

J. G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 4th 1922 to Sept 14, 1922 that I last saw him on Sept 14, 1922 and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Sarcoma of orbit

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

don't know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed)

R. B. Evans, M. D.

, 19 (Address)

411 N. Greene St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

no burial

Sept 16 1922

UNDERTAKER

ADDRESS

Wm. E. E. Co.

96 Pa. Ave

D 67595 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67595

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 S. Front St. ST.: 3 WARD)

2-FULL NAME

Donato Pellegrini

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 24 S. Front St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10-1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Donato Pellegrini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Pasqua Salvucci

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Donato Pellegrini (Address) 24 S. Front St.

15 Robert P. Harrison, Registrar

Serial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1922, to Sept 15, 1922, that I last saw him alive on Sept. 15, 1922, and that death occurred, on the date stated above, at 8 A. m. The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory Paralysis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Marasmus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Wallenstein, M. D.

19 (Address) 2042 Eufaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Cmn.

Sept 17 1922

20 UNDERTAKER

Lilly E. Zeiler

ADDRESS

4030 W. 4th

161922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

any Quinn -

date of Birth - 9-4-1920.

" " Death - 9-7-1922.

of " - 2 yr. 3 days instead of

r. 11 mos. & 3 days making the

use 114 instead of 113 -

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins St. 10* Ward)

2-FULL NAME

(Residence in Baltimore: No. *12 So Chesnut St* St.; yrs. mos. ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH. *Oct* 1922 (Month) (Day) (Year)

7-AGE. *1* yrs. *11* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *none* (b) General nature of industry, business, or establishment in which employed (or employer) *OOD*

9-BIRTHPLACE. (State or Country) *Balti*

10-NAME OF FATHER *John Quinn*

11-BIRTHPLACE OF FATHER. (State or Country) *unknown*

12-MAIDEN NAME OF MOTHER *Margaret Quinn*

13-BIRTHPLACE OF MOTHER. (State or Country) *—*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Johns Hopkins*

(Address).....

15- *Robert P. Harrison,*

Filed..... 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Sept 8* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
Autopsy made at St. Johns
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Enteritis*

(Signed) *J. S. Harrison* M. D. (Coroner.)
299 1922 (Address) *108 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER, ADDRESS, *SEP 15 1922*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 Worner2. FULL NAME Sarah Derby(a) RESIDENCE NO. 24 Worner

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos.ST. Worner WARD 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F4 COLOR OR RACE Col5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benny Derby6 DATE OF BIRTH (month, day, and year) 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66 yrs. 18 56 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) Ind
(State or country)10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown12 MAIDEN NAME OF MOTHER Sarah Boggs13 BIRTHPLACE OF MOTHER (city or town) va
(State or country)

14

Informant Maggie Nichols
(Address) Warner or unknown

15

Robert P. Harrison,

Filed 16 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1922

17

I HEREBY CERTIFY, That I attended deceased from

9-6-, 1922, to 9 13, 1922.that I last saw her alive on 9 13, 1922.and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralysis(duration) yrs. mos. 8 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? —Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? —(Signed) W. B. Hall, M. D., 19 (Address) Halethorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

St. Anthony Cemetery 3/1/16 1922

20 UNDERTAKER

ADDRESS

Mr. Scott Hooper 406 W. Carey St.

nation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicidal*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Apoplexy. Terminal
cerebral hemorrhage*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67598

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

710 Glenwood

27 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thelma Thompson

(a) RESIDENCE. NO.

710 Glenwood

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Aug 4, 1909

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

13

1

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Towson

Baltimore Md

10 NAME OF FATHER

Robert T. Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Howard Co Md

12 MAIDEN NAME OF MOTHER

Mary E. Biebel Heiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Mary E. Thompson 710 Glenwood Ave

15

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/15 1922

17

I HEREBY CERTIFY, That I attended deceased from

9/6, 1922, to 9/15, 1922,

that I last saw her alive on 9/15, 1922,

and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Zinberg M. D.

9/15, 1922 Address 1502 E. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

Sept 18, 1922

20 UNDERTAKER

J. J. Hartwell

ADDRESS

2236 W. Balto St.

Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

CAUSE OF DEATH is very important. See instructions on back of certificates.

SEP 16 1922

D 67599

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 67599

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1920 N. Lanvale ST., 16 WARD)

2. FULL NAME

William Anna Smith

(a) RESIDENCE No.

1920 N. Lanvale ST.,

WARD

(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Victor Jos. O. Smith

6 DATE OF BIRTH (month, day, and year)

May 14, 1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

67

4

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md

10 NAME OF FATHER

William Maith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Catherine Maith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Mrs. Grace M. George
1920 N. Lanvale St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 15, 1922

17

HEREBY CERTIFY, That I attended deceased from Aug 2, 1922, to Sept 14, 1922, and that I last saw her alive on Sept 15, 1922.

and that death occurred, on the date stated above, at 5: A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

About

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Atherosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. Duwall, M. D.

Address 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

London Park. Sept. 18, 1922

20 UNDERTAKER

ADDRESS

Wm. O'Neil, 502 E. North Ave

D 67600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Albion Hotel 900 Cathedral St* WARD)2. FULL NAME *Siotha W. Bennett*(a) RESIDENCE NO. *900 Cathedral St* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *8* yrs. *8* mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *widow*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*Clarence E. Bennett*6 DATE OF BIRTH (month, day, and year) *Aug 28, 1835*7 AGE Years *87* Months *17* Days *17* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Iowa* (State or country)10 NAME OF FATHER *Harvey Whitlock*11 BIRTHPLACE OF FATHER (city or town) *Iowa* (State or country)12 MAIDEN NAME OF MOTHER *Minerva Abbott*13 BIRTHPLACE OF MOTHER (city or town) *Iowa* (State or country)

14

Informant (Address)

15 Filed *Robert E. Harrison*, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 14* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Sept 14, 19 *22*, to *Sept 14*, 19 *22*that I last saw her alive on *Sept 14*, 19 *22*and that death occurred, on the date stated above, at *10¹⁶* p. m.

The CAUSE OF DEATH* was as follows:

*Angina Pectoris**at intervals for four years*

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

General arteriosclerosis

(duration) yrs. mos.

18 Where was disease contracted *unknown* if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *gross anatomical*

(Signed)

A. H. Stark

M. D.

9/14, 1922 (Address) *809 Cathedral St Balt. Md*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Arlington Era**Sept 16* 19 *22*

20 UNDERTAKER

ADDRESS

Registrar

John O. Mitchell *1201 W. Fayette*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67601

CERTIFICATE OF DEATH.

179 D 67601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 235 W. Lauvale ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Carr Barrett(a) RESIDENCE NO. 235 W. Lauvale ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) May 13, 18537 AGE Years 69 Months 4 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md10 NAME OF FATHER Must Barrett11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md12 MAIDEN NAME OF MOTHER Margt. M. Balbach13 BIRTHPLACE OF MOTHER (city or town) Phila (State or country) Pa14 Informant Must Barrett (Address) 235 W. Lauvale St15 Filed Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 19 2217 I HEREBY CERTIFY, That I attended deceased from Aug 23, 19 22, to Sept 15, 19 22, that I last saw him alive on Sept 15, 19 22, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Jones, M. D.19 PLACE OF BURIAL, CREMATION, OR RE-MOVAL 720 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-MOVAL

Roudon Park Sept 18, 1922

20 UNDERTAKER ADDRESS

John Ottitchell 1201 W. Fayette St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

STROUSE

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67602

CERTIFICATE OF DEATH.

D 67602

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Riviera Apts., ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kathilda Strouse,(a) RESIDENCE NO. Riviera Apts. ST. 13 WARD 13
(Usual place of abode) (If non-resident give city or town and State)Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female, 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow,5a If married, widowed, or divorced
HUSBAND of Leopold Strouse,
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Aug. 24th. 19457 AGE Years 77. Months 02 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany,
(State or country)10 NAME OF FATHER Ansel Michel,11 BIRTHPLACE OF FATHER (city or town) Germany,
(State or country)12 MAIDEN NAME OF MOTHER Feist,13 BIRTHPLACE OF MOTHER (city or town) Germany,
(State or country)14 Informant Mrs. T. Seldner
(Address)15 Filed SEP 10 1922 19 22 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15th. 192217 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922, to Sept 15, 1922,that I last saw him alive on Sept 15, 1922,and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis
(duration) 1 yrs. mos. ds.CONTRIBUTORY (Secondary) Myocarditis
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical signs(Signed) John F. Seldner, M. D., 1922 (Address) 1215 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Clark Shalom DATE OF BURIAL Sept 17 192220 UNDERTAKER David Soudner ADDRESS 11801 W. 4th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67603

CERTIFICATE OF DEATH.

D 67603

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1241 E Lexington ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna Damm(a) RESIDENCE NO. 1241 E Lexington ST., 5 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced

(or) WIFE of

Harry Damm6 DATE OF BIRTH (month, day, and year) Jan 18 18487 AGE Years 74 Months 7 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

William Hasselhoff

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Meta Shageman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Mrs Emma Damm
1241 E Lexington St

15

Filed

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1922, to Sept. 14, 1922, that I last saw him alive on Sept. 14, 1922,and that death occurred, on the date stated above, at 11:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no, Date ofWas there an autopsy? no,

What test confirmed diagnosis?

(Signed) Robt. J. Green, M. D.7-15, 1922 (Address) 1200 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Carmel Cemetery

DATE OF

Sept 18 1922

20 UNDERTAKER

George Schilling 126 E. Mount St

D 67604 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67604

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4201 Springdale Ave. 28 ST.: 28 WARD)

2-FULL NAME

Ida Lee Lohmeyer

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 4201 Springdale ST., 28 WARD. Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? 61 yrs. 11 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Otto Lohmeyer

6 DATE OF BIRTH (month, day, and year) Sept-28-1860

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 61 11 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Wm. Henry Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Rebecca Lusk

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

PARENTS

14 Informant

(Address)

Otto Lohmeyer (husband) 4201 Springdale Ave.

15 Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 16, 1922, to Sept 14, 1922 that I last saw her alive on Sept 14, 1922.

and that death occurred, on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed)

C. K. Skilling, M. D.

9-15-1922 (Address) 1120 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery Sept 16 1922

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67605 HEALTH DEPARTMENT—CITY OF BALTIMORE 67605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME.

(Residence in Baltimore: No.

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH.

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) (Coroner)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS

Scalding water

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

peritonium, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia," (merely symptomatic), "At-rophy," "Collapse," "Coma," "Convulsions," "De-bility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite dis-ease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERP-ERAL peritonitis," etc. State cause for which sur-gical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Ex-amples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homi-cide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional in-formation which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyemia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicemia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67606

46 D 67606

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 S. 1st ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Downes

(a) RESIDENCE NO. 500 S 1st
(Usual place of abode)

ST. 76 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Downes

6 DATE OF BIRTH (month, day, and year) Aug 13, 1866

7 AGE Years 56 Months 1 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

10 NAME OF FATHER Henry Ritter

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Charles Downes
(Address) 500 S 1st

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1922, to Sept 14, 1922, that I last saw her alive on Sept 14, 1922, and that death occurred, on the date stated above, at 10:45 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus
(duration) yrs. 8 mos. ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell, M. D.
, 19 (Address) 152 N. Miller St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mount Carmel Cem

DATE OF BURIAL Sept 18 1922

20 UNDERTAKER John Kellerish
ADDRESS 2008 Calver

161922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67607

D 67607

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

63

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

House Work

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

Laural Cooper

1213 Lombard Street

15

Filed

19

Registrar

16

1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 11 1922 to Sept. 14 1922

that I last saw her alive on Sept 14 1922

and that death occurred, on the date stated above, at 10 am.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S.W. Rourke, M.D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

National Cemetery

DATE OF BURIAL

Sept 15 1922

20 UNDERTAKER

Mrs Robert A. Elliot

ADDRESS 1725

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67608

1-PLACE OF DEATH

44 D 67608

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1542 Argyle St. ST. 14 WARD)2-FULL NAME Georgiana Roberts Hapewell(a) RESIDENCE. No. 1542 Argyle Ave ST. 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed6 DATE OF BIRTH (month, day, and year) 18577 AGE Years 64 Months 11 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eastville (State or country) Virginia10 NAME OF FATHER John Roberts11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia12 MAIDEN NAME OF MOTHER Not Known13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant Mary A. Peate (Address) 201 Division St.15 Filed SEP 16 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 14 19 2217 I HEREBY CERTIFY, That I attended deceased from June 14th 19 22, to Sept 14, 19 22, that I last saw him alive on Sept 14th, 19 22, and that death occurred, on the date stated above, at 12:20 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical findings(Signed) Samuel H. Hays M. D.19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Trinity Lutheran Church 9-17 19 22

20 UNDERTAKER ADDRESS

George H. Holland 1631 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67609

D 67609

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 534 Baker

ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Bowden

(a) RESIDENCE. NO. 534 Baker

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

72

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

9/12 1922 to 9/15 1922

that I last saw him alive on 9/14 1922

and that death occurred, on the date stated above, at 3:45 A. M.

The CAUSE OF DEATH* was as follows:

Semi-coma x
Cerebral apoplexy x
Paralysis x
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. R. L. H. M. D.

9/16 1922 (Address) 2134 J. St. A

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Paul's Church 9-17 1922

20 UNDERTAKER

ADDRESS

George T. A. Gibson 513 Lawrence

tion should be carefully supplied. Age should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 16 1922

D 67610 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1942 Druid Hill Ave. Ward) 14

Registered No. C. 67610

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1942 Druid Hill Ave. St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female 4-COLOR OR RACE, colored 5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH. 11/18/1890 (Month) (Day) (Year)

7-AGE. 32 yrs. 3 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. nurse (maid) (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Virginia

PARENTS. 10-NAME OF FATHER. 11-BIRTHPLACE OF FATHER, (State or Country). 12-MAIDEN NAME OF MOTHER. 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Letty Gross

(Address) 1942 Druid Hill Ave.

15- Robert P. Harrison,

Filed 1922 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Dec 14, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute gastro-enteritis (Duration) 7 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of heart (Duration) 5 yrs. 1 mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner)

Sept. 15, 1922 (Address) 2802 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St. Mary's Cemetery 9-11, 1922

20-UNDERTAKER. ADDRESS.

George E. A. Gibson 513 Laurel

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67611

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Provident Hospital* ST., *118* WARD)

2-FULL NAME

(a) RESIDENCE NO. *Kilmorock, Lancaster Co., Va.* ST., *118* WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. *4* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 16 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Sept 13 1922, to *Sept 16 1922*, that I last saw him alive on *Sept 16 1922*and that death occurred, on the date stated above, at *3 A.* m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction + Multiple Intestinal Adhesions

(duration) yrs. mos. ds.

CONTRIBUTORY

Hernia

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harry F. Brown*, M. D.(Address) *1501 Prestman St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JAMES H. DENNIS

1501 PRESTMAN ST.

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

171922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67612

CERTIFICATE OF DEATH.

164 D 67612

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin* ST.; *22* WARD)2-FULL NAME *Ferdinand Gohr*(a) RESIDENCE. No. *Franklin* ST., *22* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.How long in U. S., if of foreign birth? *40* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of *Victoria Gohr*
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Nov. 3 1827*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 16 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Sept 14, 1922, to Sept 16, 1922
that I last saw him alive on *Sept 16, 1922*and that death occurred, on the date stated above, at *9309*

The CAUSE OF DEATH* was as follows:

*Hypertensive Congestion of
Lungs*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Amputation*(Signed) *A. C. Semm*, M. D.Address *4109 Gehrig Hg*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Exact statement of occupation should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

17 1922

*Smink Liberty Heights**William Cook 502 E. Pratt*
H W 2474

D 67613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2934 St. Paul St.

ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josias Green Craemer

(a) RESIDENCE. No. 2934 St. Paul St.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs. ?

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)

married

5a If married, widowed or divorced

HUSBAND of
XXXXXXXXSarah Cassandra
Craemer

6 DATE OF BIRTH (month, day, and year) April 28, 1858

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

64

4

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Chief Clerk

(b) General nature of industry,
business, or establishment in
which employed (or employer)Bureau of inspection
Lumber exchange

(c) Name of employer

9 BIRTHPLACE (city or town) Patapsco, Neck
(State or country) Balto. Co. Md

10 NAME OF FATHER William Craemer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Green

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland14 Informant Mr. Charles Long
(Address) 2934 St. Paul St.

15 Filed Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 15, 1922 19

17

I HEREBY CERTIFY, That I attended deceased from
July 26th, 1922, to Sept. 15th, 1922
that I last saw him alive on Sept. 14th, 1922

and that death occurred, on the date stated above, at 6:45 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
of about
4 or 5 months duration
probablyCONTRIBUTORY
(Secondary)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No. Date of X

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Clarence C. Prie, M. D.

, 19 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

9-18-22 19

20 UNDERTAKER

ADDRESS

H. E. Hughes

424 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

D. 67614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 67614

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

Hehren Hospital

ST.

WARD)

2-FULL NAME

Israel Terliky

(Residence in Baltimore: No.

403 N. Wolf Street

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

Unknown

(Month)

(Day)

(Year)

7-AGE,

55

yrs.

mos.

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Storekeeper

9-BIRTHPLACE,
(State or Country),

Russia

10-NAME OF FATHER,

Zisa Terliky

11-BIRTHPLACE OF FATHER,
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Rosa Dubra

13-BIRTHPLACE OF MOTHER
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jack Lewis

(Address)

1439 E. Baltimore

15-

Filed

101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

17

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Teller

(Coroner.)

M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hehren Hospital

9-17, 1922

20-UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

N. H.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION. Important. See instructions on back of certificate.

N. H. 17 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67615

CERTIFICATE OF DEATH.

90 D 67615

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Edmondson Ave. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary A. Lewis

(a) RESIDENCE NO.

1016 Edmondson Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Alonzo B. Lewis

6 DATE OF BIRTH (month, day, and year) Dec. 3 1844

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

77

9

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Retired

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Dress Maker

(c) Name of employer

At Home

9 BIRTHPLACE (city or town)
(State or country)

Virginia

10 NAME OF FATHER Bennett C. Scarborough

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Martin

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant
(Address)

Miss Mollie Lewis (Daughter)

1016 Edmondson Ave.

15

Filed

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep't 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct-29 1918 to Sept 16 1922

that I last saw him alive on July 6 1922

and that death occurred, on the date stated above, at 6 A.M. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

CONTRIBUTORY
(Secondary)

(duration) 3 yrs. 10 mos. 19 ds.

Cardiac Insufficiency

(duration) 3 yrs. 10 mos. 19 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Frances A. Carpenter, D.

Self 16, 1922 (Address) 2101 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Cedar Hill Cem

Sept 18 1922

John F. Denny Ligon Montgomery

tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P 117 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67616

CERTIFICATE OF DEATH.

113 D 67616

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 S. Fulton Ave. ST. 19 WARD)

2-FULL NAME

(a) RESIDENCE NO. 215 S. Fulton Ave. ST. 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21, 19217 AGE Year 1 Months 2 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Theodore Roehnle11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Emma E. Klein13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant Mrs. T. Roehnle (mother) (Address) 215 S. Fulton Ave.15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 192217 I HEREBY CERTIFY, That I attended deceased from Sept 13th, 19 22, to Sept 15, 19 22, that I last saw him alive on Sept 15, 19 22, and that death occurred, on the date stated above, at 11:55 A.M.

The CAUSE OF DEATH* was as follows:

MarasmusCONTRIBUTORY (Secondary) Diarrhoea (duration) 5 weeks yrs. mos. ds.18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical Exam (Signed) J. W. Clark, M. D.15, 1922 (Address) 142 N. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Western

DATE OF BURIAL

20 UNDERTAKER Mrs. N. S. Fink

ADDRESS

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67617

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67617

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2218 Henneman Ave* ST.: *8* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George Kammer(a) RESIDENCE. NO. *2218 Henneman Ave* ST., *8* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *42* yrs. *11* mos. *27* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Mamie Kammer*

6 DATE OF BIRTH (month, day, and year)

Aug. 18-1880

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*42**11**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Pittsburgh Glass Co.*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto Md.*

10 NAME OF FATHER

Peter Kammer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Mary Wolf

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant
(Address)*Mamie Kammer
2218 Henneman Ave*

15

Robert F. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *September 16 1922*

17

I HEREBY CERTIFY, That I attended deceased from
September 8, 19*22*, to *September 16*, 19*22*,
that I last saw him alive on *September 16*, 19*22*,
and that death occurred, on the date stated above, at *11:00 A.* m.
The CAUSE OF DEATH* was as follows:*General Arteriosclerosis*(duration) *unknown* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Angina Pectoris*(duration) yrs. mos. *10* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

Frank J. Ayer

M. D.

Sept 16 1922(Address) *2005 E. Monument St.**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Balto Cem**Sept 19 1922*

20 UNDERTAKER

Philip Henry

ADDRESS

2016 Calver

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17 1922

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

157321 HEALTH DEPARTMENT—CITY OF BALTIMORE
D 67618 67618
CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

ST.,

WARD)

CITY OF BALTIMORE: (No.)

2-FULL NAME

Charles F. Thompson.

(a) RESIDENCE NO.

Clarksburg, W. Va.

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White

Widowed.

6 If married, widowed, or divorced

703 E. St. Washington D.C.

(Jan)

(or) WIFE of

Charles W. Thompson.

6 DATE OF BIRTH (month, day, and year)

Jan. 28, 1856.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

7

19.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Traveling salesman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

W. Virginia.

10 NAME OF FATHER

Samuel Thompson.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

W. Virginia.

12 MAIDEN NAME OF MOTHER

Mary Randolph.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W. Virginia.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

Records

15

SEP 13 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 17 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 9, 1922, to Sept 17, 1922.

that I last saw him alive on Sept 17, 1922.

and that death occurred, on the date stated above, at 3:50 P. m.

The CAUSE OF DEATH* was as follows:

1) Carcinoma of Prostate

2) Cachexia

CONTRIBUTORY (Secondary) (duration) ? yrs. ? mos. ? ds.

Bronchopneumonia (duration) ? yrs. ? mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) W. H. E. V. man, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Burial

20 UNDERTAKER

Joseph W. W. W.

DATE OF BURIAL

Sept 17, 22

ADDRESS

221 N. B. W.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *210 Carey* ST., *19* WARD)2. FULL NAME *Paul Stein*(a) RESIDENCE NO. *210 Carey* ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *White*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Sept 1-1920*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*2**16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *none*9 BIRTHPLACE (city or town) *Baltimore*
(State or country)10 NAME OF FATHER *Michael Stein*11 BIRTHPLACE OF FATHER (city or town) *Serbia*

(State or country)

12 MAIDEN NAME OF MOTHER *Ethel Spearman*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore*

(State or country)

14

Informant
(Address) *Michael Stein
210 S. Carey St.*

15

Filed *SEP 16 1922*Registrar *OK*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *9/16/22* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *9/15/22* 19 *22* to *9/16/22* 19 *22*,
that I last saw him alive on *9/16/22* 19 *22*,
and that death occurred, on the date stated above, at *4 30 a* m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration)

yrs.

mos. *3*

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) *Thos. L. Driscoll*

M. D.

19

(Address) *1000 Columbia Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *St. Peter's Cemetery*

DATE OF BURIAL

9/18 19 *22*20 UNDER-TAKER *Robert B. McKee*ADDRESS *Cathow**Hollins*Exact statement of OC, PA-
tion should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67620

67620

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Ff yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 24, 1922 to Sept. 14, 1922 that I last saw him alive on Sept. 14, 1922

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia (terminal)

CONTRIBUTORY (duration) yrs. mos. ds.

(Second) Arterio Sclerotic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) H. Fred Smith M. D.

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated in years. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 18 1922

19 PLACE OF BURIAL, CREMATION OR RE-
 20 UNDERTAKER
 R B Cross 1405 Maryland

D 67621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67621

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 W. Hamburg ST. 23 WARD)

2-FULL NAME

Susana Stanley

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

410 W. Hamburg ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

63 yrs.

- mos.

- ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Spencer Stanley

6 DATE OF BIRTH (month, day, and year)

Sept, 1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

@ home

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

George W. Milburn

11 BIRTHPLACE OF FATHER (city or town)

Somerset Co.

(State or country)

Mary land

12 MAIDEN NAME OF MOTHER

Ellen Barnes

13 BIRTHPLACE OF MOTHER (city or town)

Frederic Co.

(State or country)

Mary land

14

Informant

Victoria Moore

(Address)

410 W. Hamburg St

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept, 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb, 5, 1922, to Sept, 15, 1922.that I last saw her alive on Sept, 14, 1922.and that death occurred, on the date stated above, at 9:45 a m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) David Traubner M. D.9/16, 1922 (Address) 12 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. AuburnSept 18, 1922

20 UNDERTAKER

ADDRESS 142John H. Toadum Wheat St

tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCASION OF DEATH is very important. See instructions on back of certificates.

SEP 16 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67622

D 67622

CERTIFICATE OF DEATH.

74-001
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 E Monument ST., 40 WARD)

2-FULL NAME

Emma Jane Mills

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1009 E. Monument ST., 51 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

(Divorced.)

6 DATE OF BIRTH (month, day, and year)

Aug 18, 1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

67

0

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired dress

(b) General nature of industry, business, or establishment in which employed (or employer)

maker, at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

James L. Mills,

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Annapolis Md.

12 MAIDEN NAME OF MOTHER

Eliza Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant

(Address)

Mrs. Annie Sutherland, 1009 E Monument St. (dist.)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 15, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 20, 1922, to Sept 15, 1922.

that I last saw her alive on Sept 15, 1922.

and that death occurred, on the date stated above, at 2:00 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

9/15/22

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery

Sept 18, 1922

UNDERTAKER

ADDRESS

Liston P. Fussell & Co 2620 St Paul,

tion should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION should be supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SEP 18 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No.

ST.,

WARD)

2-FULL NAME

Washington Carr

(a) RESIDENCE NO.

(Usual place of abode)

Elmhurst St.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Black

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 9, 1862?

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Annapolis Md

10 NAME OF FATHER

William Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Nancy Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

Filed

19

Registrar

ROBERT P. HARRISON,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1922

17

HEREBY CERTIFY, That I attended deceased from Sept 6, 1922, to Sept 15, 1922, that I last saw him alive on Sept 15, 1922, and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis, hypertension.

CONTRIBUTORY (Secondary) (duration) 3 yrs. mos. ds. Cerebral hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Glenburnie Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Signed) E. Cowles Andrews, M. D.

Address John Hopkins Hosp. 9/16/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Broad Neck A.C. Co. 9/18/22

ADDRESS 5782

Burial Undertaker Samuel J. Hensley

D 67624

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 67624

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mary Hospital*CITY OF BALTIMORE: (No. *Calvert + Saratoga Sts. 71* WARD)2-FULL NAME *Mrs. Marnie Edgerton*(a) RESIDENCE No. *5 Roland Ave.* ST.

(Usual place of abode)

Length of residence in city or town where death occurred

58 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Rayard C. Edgerton,

6 DATE OF BIRTH (month, day, and year)

October 18, 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58 10 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John D. Sauerberg

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Amie H. Gorman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant (Address)

F. D. Weaver
5 Roland Ave.

15

Filed

Robert P. Harrison,

, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

*May 4, 1922, to Sept 16, 1922.*that I last saw her alive on *Sept 16*, 1922,and that death occurred, on the date stated above, at *1:30 P.m.*

The CAUSE OF DEATH* was as follows:

Malignancy of Mediastinum(duration) *1* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted

if not at place of death?

*at place of birth*Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

X-Ray

(Signed)

C. G. McCoy

M. D.

SEP 15 1922

(Address)

Mary Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Druid Ridge

DATE OF BURIAL

SEP 17 1922

19

20 UNDERTAKER

ADDRESS

*John R. Gorman**1325 N. Caroline St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67625

D 67625

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *York Rd & Homeland* St.: *27* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Elizabeth Weber (WEBER)(Residence in Baltimore: No. *5234 York Rd* St.: *18* yrs., mos. ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

*white*5-SINGLE, MARRIED, *Single* WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

June 18, 1896
(Month) (Day) (Year)

7-AGE,

26 yrs. 2 mos. 29 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *House work*(b) General nature of industry, business, or establishment in which employed (or employer) *off*

9-BIRTHPLACE, (State or Country),

Elmhurst City - Howard Co

10-NAME OF FATHER,

H. T. Weber

11-BIRTHPLACE OF FATHER (State or Country),

Ellicott City, Md

12-MAIDEN NAME OF MOTHER

Emma N. Hohn

13-BIRTHPLACE OF MOTHER (State or Country),

Beth, Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. H. T. Weber*(Address) *5234 York Rd*

15-

Robert P. Harrison,

1922

191

Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 11, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*June 14 1922, to September 11 1922*that I saw her alive on *September 16 1922*and that death occurred, on the date stated above, at *10:30 a.m.*

The CAUSE OF DEATH* was as follows:

*Graves Disease**Chronic Myocarditis**(Duration) 2 yrs. 2 mos. 29 ds.*CONTRIBUTORY (Secondary) *Acute Cardiac Distention**(Duration) 2 yrs. 2 mos. 29 ds.*(Signed) *D. W. Bishop* M. D.*Sept. 12, 1922* (Address) *551 Sheridan Ave.*

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *18* yrs. mos. ds. In the State *26* yrs. 2 mos. 29 ds.Where was disease contracted, if not at place of death? *Same*Former or usual residence *Same*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt. Clear Cem (Gosly & Co.) Sept. 18, 1922

20-UNDERTAKER ADDRESS

Joseph B. Cook 1003 N. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emerson Ledley(a) RESIDENCE NO. Bay View AsylumST. 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds.(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1879

7 AGE

Years

Months

Days

If LESS than
1 day,hrs
ormin.43----

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workNone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Aleck Ledley11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Vincent13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14

Informant Hospital Records(Address) Municipal Hospital

15

Robert P. Harrison,

Filed 1922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 14 19 22

17

I HEREBY CERTIFY, That I attended deceased from

November 17, 1922, to Sept. 14, 19 22.that I last saw him alive on September 14, 19 22.and that death occurred, on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Infantile Cerebral Palsy(duration) 43 yrs. mos. ds.CONTRIBUTORY
(Secondary)Epilepsy(duration) 43 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde M. Hunt M. D.16/19 22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Louisa Park Cem. Sept 18, 22

20 UNDERTAKER

Joseph B. Cook 1003 N. Baltimore

ADDRESS

mation should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P 11 1922

D 67627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67627

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2322, E. Federal* ST., *8* WARD)2-FULL NAME *Elsie M Fogarty*(a) RESIDENCE NO. *2322 E Federal* ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred *7* yrs. _____ mos. _____ ds. _____

How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. _____

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

*Maurice F. Fogarty*6 DATE OF BIRTH (month, day, and year) *April 2, 1896*

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

*26**5**14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Homemaker**at home*

9 BIRTHPLACE (city or town) _____ (State or country) _____

10 NAME OF FATHER *George M Bristow*

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____

12 MAIDEN NAME OF MOTHER *No*

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____

14

Informant *Mr Maurice F. Fogarty*(Address) *2322 E. Federal St*

15

Filed *EP 18 1922*Registrar *John T. Denny*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 16 1922*

17

I HEREBY CERTIFY That I attended deceased from

*August 22, 1922, to Sept 15, 1922,*that I last saw him alive on *Sept 15, 1922,*and that death occurred, on the date stated above, at *2 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) *1* yrs. _____ mos. *22* ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of _____Was there an autopsy? *No*What test confirmed diagnosis? *Pulmonary*(Signed) *E. J. Jones* M. D.*Sept 19* (Address) *1301 N. Paul St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Woodlawn Cemetery

20 UNDERTAKER

John T. Denny

DATE OF BURIAL

Sept 19 1922

ADDRESS

715 Lois St

mation should be carefully supplied. AGE should be stated. Exact statement of OCCASION OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hospital* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)2-FULL NAME *Mary Watson*(Residence in Baltimore: No. *2224 Preston Place* St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*6-DATE OF BIRTH, *March* 1900 (Month) (Day) (Year)7-AGE, *22* yrs. *6* mos.ds. If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Homemaker*
(b) General nature of industry, business, or establishment in which employed (or employer) *031*9-BIRTHPLACE, (State or Country), *Balt. Md.*10-NAME OF FATHER, *Isaac Louis*11-BIRTHPLACE OF FATHER, (State or Country), *France*12-MAIDEN NAME OF MOTHER, *Lue Douc*13-BIRTHPLACE OF MOTHER, (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Johns Hopkins Hosp.*

(Address).....

15- *Robert P. Harrison,*

Filed.....192..... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 15* 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or Inquiry.)thereon and from the evidence obtained by said *inquiry* find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.The CAUSE OF DEATH* was as follows:
Spontaneous due to abortion, which occurred about Sept 1/2
(Duration).....yrs.....mos.....ds.CONTRIBUTORY (Secondary) *None*(Signed) *J. H. Harrison* M. D. (Coroner.)9-17-1922 (Address) *508 E North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Park by Sept 28, 1922

20-UNDERTAKER, ADDRESS

for residents 207 S. Bay

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67629

D 67629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *329 N. Schroeder* ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *329 N. Schroeder* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *71* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Mar.

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Annie E. Base

6 DATE OF BIRTH (month, day, and year)

Aug. 27 1841

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*81**1**21*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Doctor

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Saml Base

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Rosie Jeff

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Annie E. Base
329 N. Schroeder

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 17 1922

17

I HEREBY CERTIFY, That I attended deceased from *Sept. 10*, 19*22*, to *Sept 17*, 19*22*.that I last saw him alive on *Sept 17*, 19*22*.and that death occurred, on the date stated above, at *10 A. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cemetery**Sept 19 1922*

20 UNDERTAKER

ADDRESS

for Frederickson Son 217 S. Penn

Exact statement of OCCUPATION should be carefully reported. See instructions on back of certificates.

SEP 18 1922

D 67630

HEALTH DEPARTMENT—CITY OF BALTIMORE

169 D 67630

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Waxters Ice Pond* St. *Ward*)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anna Wees(Residence in Baltimore: No. *1514 N. Spring St.* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-Single, Married, *Married*, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, 1. 8. 8. 9

(Month) (Day) (Year)

7-AGE, 38 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Housewife*9-BIRTHPLACE, (State or Country), *Md.*10-NAME OF FATHER, *Wm. Shuster*11-BIRTHPLACE OF FATHER, (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Unknown*13-BIRTHPLACE OF MOTHER, (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edward Bush*(Address) *2326 E. Preston St.*15- *Robert P. Harrison*

Filed, 1922 Burial Permit Office, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *found Sept 16*, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held no. *Investigation* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said. *Investigation* (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.The CAUSE OF DEATH* was as follows: *Drowned Suicide*(Duration) *Sudden* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *James M. Farlow* M. D. (Coroner.)Sept. 18, 1922 (Address) *700 E. Chase St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

*Waxters Ice Pond*Former or usual residence, *1514 N. Spring St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore *Sept. 12, 1922*

20-UNDERTAKER, ADDRESS

Leo G. Hook *North Harford*

D 67631

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 67631

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 880 Washington Blvd ST. 21 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

66 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 19 22, to Sept 18, 19 22,that I last saw him alive on Sept 16, 19 22,and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic degenerative
myelitis and uremia.(duration) 8 yrs. mos. ds.CONTRIBUTORY
(Secondary)(duration) 5 yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. G. Hunt, M. D., 19 (Address) 1000 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 67632 HEALTH DEPARTMENT—CITY OF BALTIMORE **CERTIFICATE OF DEATH.**

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Percy W. (Harris) Clark(a) RESIDENCE. NO. 3825 Dalrymple ST., _____ WARD. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of
WIFE ofPercy W. Clark6 DATE OF BIRTH (month, day, and year) Dec. 26, 1871

7 AGE Years 50 Months 8 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti
Md

10 NAME OF FATHER

Wm A Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary A Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant
(Address)Mrs Percy W Clark
3825 Dalrymple Ave

15

Eld

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

9-14, 1922, to 9-16, 1922.that I last saw her alive on 9-16, 1922.and that death occurred, on the date stated above, at 6:15 p.m.

The CAUSE OF DEATH* was as follows:

mesenteric thrombosis
with gangrene of 18 inches
of small intestine(duration) yrs. mos. 6 ds.CONTRIBUTORY
(Secondary)Intestinal obstruction(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-14Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H B Price, M. D.19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cem Sept. 18 1922

20 UNDERTAKER

Wm J. McKenney North Pa

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67633

D 67633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Maryland General Hospital* ST.: *10* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *Francis M. Luckett* ST.: *502 N. Fulton Ave* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *6* yrs. *—* mos. *—* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of *Margaret W. Luckett*6 DATE OF BIRTH (month, day, and year) *Oct 16 1866*7 AGE Years *55* Months *11* Days *0* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Retired*(b) General nature of industry, business, or establishment in which employed (or employer) *Mariner*(c) Name of employer *Washington*9 BIRTHPLACE (city or town) (State or country) *etc*10 NAME OF FATHER *Francis Luckett*11 BIRTHPLACE OF FATHER (city or town) (State or country) *etc*12 MAIDEN NAME OF MOTHER *Jane Dorr*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *etc*14 Informant *Margaret W. Luckett* (Address) *502 N. Fulton Ave*15 *Robert P. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 15 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept 3* 19 *22* to *Sept 15* 19 *22*.that I last saw him alive on *Sept 15* 19 *22*.and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

*1. Chronic Cholecystitis*CONTRIBUTORY (Secondary) *Chronic Pancreatitis* (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *No* Date of.Was there an autopsy? *Yes*What test confirmed diagnosis? *Clinical, Autopsy*(Signature) *James Hubert Kilgerson* M. D.19 (Address) *44 General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Thompson Ave *Sept 18 1922*20 UNDERTAKER *H. J. L. L. L.* ADDRESS *North*

SEP 18 1922

Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67634

D 67634

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 124 S. Schroeder

ST. 18 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 124 S. Schroeder

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male.

4 COLOR OR RACE

white.

5 Single, Married, Widowed, or Divorced (write the word)

married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma Linkhust

6 DATE OF BIRTH (month, day, and year)

Mar 26-1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

5

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

B & O R R

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John Burg

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaretta Rockell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Mrs Emma Linkhust 124 S. Schroeder St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan - 1922, to Sept 16 - 1922, that I last saw him alive on Sept 16, 1922

and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Coriatic Dis - Valvular -

CONTRIBUTORY (Secondary) (duration) 1 yrs. mos. ds. Hydrothorax - Coriatic failure (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine

(Signed) J. H. Brown M. D.

19 (Address) 125 S. Schroeder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park View

Sept 19 1922

20 UNDERTAKER

J. H. Brown

ADDRESS

901 Holmes

Information should be carefully supplied. Exact statement of occupation and cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

18 1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67635

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1117 N. Central Ave. ST., 10 WARD)

2-FULL NAME

Philip B. Hartman

(a) RESIDENCE NO.

1117 N. Central Ave.

ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 4 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Margaret Hartman

6 DATE OF BIRTH (month, day, and year)

Oct. 12 1865

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

56

11

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Clothing

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Cutter

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Herman B. Hartman

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Not Known

14

Informant
(Address)Mrs Margaret Hartman
1117 N. Central Ave.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1922

17

HEREBY CERTIFY, That I attended deceased from
Sept. 1, 1922, to Sept. 15, 1922,
that I last saw him alive on Sept. 15, 1922
and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Convulsions

CONTRIBUTORY
(Secondary)(duration) 2 days
yrs. mos. ds.(duration) 15
yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms
(Signed) P. J. Schell, M. D.

IX. 16. 1922 (Address) 1001 Broadway St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Redeemer Cemetery

Sept. 19 1922

20 UNDERTAKER

ADDRESS

Henry Hock Sun

1301 E. Eager St.

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

D 67636

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *954 Bisquit*) ST.: *10* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Clara C. Brockmeyer*(Residence in Baltimore: No. *954 Bisquit* St.; *Lifetime* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Nov. 27, 1856*
(Month) (Day) (Year)7-AGE, *5 yrs. 9 mos. 19 ds.* If LESS than 1 day, ...hrs. or ...min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer) *at home*9-BIRTHPLACE, (State or Country), *Baltimore Md.*10-NAME OF FATHER, *George Petri*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER *unknown*13-BIRTHPLACE OF MOTHER (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. L. Brockmeyer (son)*(Address) *954 Bisquit St.*

15-

Filed *Robert P. Harrison,* 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 16, 1922*
(Month) (Day) (Year)17. I HEREBY CERTIFY, That I attended deceased from *Jan. 5, 1922*, to *Sept. 16, 1922*, that I saw her alive on *Sept. 16, 1922*, and that death occurred, on the date stated above, at *10 a. m.*

The CAUSE OF DEATH* was as follows:

Hemorrhage (cerebral)(Duration) *4* yrs., *4* mos., *4* ds.CONTRIBUTORY (Secondary) *Stroke - Schrot's*(Duration) *4* yrs., *4* mos., *4* ds.(Signed) *T. J. Peckold* M. D.*18. 16, 1922* (Address) *1001 Bisquit St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *3* yrs., *4* mos., *19* ds. In the *Lifetime* State *1* yrs., *4* mos., *4* ds.Where was disease contracted, if not at place of death? *unknown*Former or usual residence *954 Bisquit St.*

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer Church DATE OF BURIAL, *Sept. 19, 1922*20-UNDERTAKER *Henry Horck Sur* ADDRESS *1301 E. Eager St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67637

CERTIFICATE OF DEATH

49 D 67637

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 323 S Clinton ST. 26 WARD)

FULL NAME

Edward H. Sanders

(Residence in Baltimore: No.

323 S Clinton St.

St. 50 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 MARRIED ~~WIDOWED~~ ~~DIVORCED~~ ~~WIDOWED~~ ~~DIVORCED~~ (Write the word)

6 DATE OF BIRTH March 25, 1852 (Month) (Day) (Year)

7 AGE 70 yrs. 5 mos. 21 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

United Railway 078

9 BIRTHPLACE (State or country)

Germany

10 NAME OF FATHER

Gerhard H. Sanders

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Agathe Sanders

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Elizabeth Sanders (Informant)

(Address) 323 S Clinton

15.

Robert P. Harrison,

16.

191

Parish Peralt Clerk, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September 16, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1921 to Sept. 16, 1922.

that I saw him alive on Sept. 16, 1922.

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

(Duration) 2 yrs. mos. ds.

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Frank A. Glantz M. D.

Sept. 17, 1922 (Address) 3244 East a

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

Mount Carmel Cem

DATE OF BURIAL

Sept 20, 1922

20. UNDERTAKER

John Miller

ADDRESS

2008 Alameda

D 67638

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67638

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Do. Balt. Hospital 24* St. *24* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *638 E. Clements* St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*6-DATE OF BIRTH. *Oct. 28, 1921* (Month) (Day) (Year)7-AGE. *10* yrs. *20* mos. *20* ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer). *None*9-BIRTHPLACE, (State or Country) *Baers - Ind.*10-NAME OF FATHER, *John C. Ludwig*11-BIRTHPLACE OF FATHER, (State or Country) *Baers - Ind.*12-MAIDEN NAME OF MOTHER, *Agnes C. Cusper*13-BIRTHPLACE OF MOTHER, (State or Country) *Baers - Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John C. Ludwig*(Address) *638 E. Clements*

15-

Filed *Robert P. Harrison* 192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 16, 1922* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *Inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *her* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Auto accident
Fracture of Skull
(Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *Locks*(Signed) *Geo. B. Miller* (Duration) yrs. mos. ds.(Address) *143 N. Broadway* 192 (Address) 192

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cedar Hill *9/18/22* 19

20-UNDERTAKER, ADDRESS

John J. Stump *1318 Light St.*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

P

81922

D 67639 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 67639
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Barnes(a) RESIDENCE NO. Unknown

(Usual place of abode)

ST. 76 WARD(If non-resident give city or town and State)
Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofUnknown6 DATE OF BIRTH (month, day, and year) 18547 AGE 68 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records,
(Address) Municipal Hospital.15 Filed 1922, 19 18 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 19 2217 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 19 22, to Sept. 16, 19 22, that I last saw him alive on Sept. 15, 19 22.and that death occurred, on the date stated above, at 12:10 A.M.

The CAUSE OF DEATH* was as follows:

Degenerative myocarditis
(duration) 10 yrs. mos. ds.CONTRIBUTORY
(Secondary)Arteriosclerosis
(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde M. Smith M. D.Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Exact statement of cause of death should be stated on back of certificate. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

18 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

67640

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1805-Maryland ST. WARD)

2-FULL NAME

(a) RESIDENCE. No. 1805-Maryland ST. WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE C 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec. 26 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 7 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Charles G. Gindgen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Mary Gindgen 1805 Maryland Ave

15 Filed 1922 Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1922

17 I HEREBY CERTIFY, that I attended deceased from Sept. 12, 1922, to Sept. 15, 1922, that I last saw him alive on Sept. 15, 1922, and that death occurred, on the date stated above, at 6:10 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) P. G. Gindgen M. D.

1116 122 (Address) 1134 - Street Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Interment

DATE OF BURIAL

Sept 18 1922

20 UNDERTAKER

Joseph A. Farrell

ADDRESS

1312 Madison

D 6764

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 Patung St. 4 WARD)

2-FULL NAME

(Residence in Baltimore: No. 706 Patung St.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 30 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-STATUS
MARRIED, *Married*
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer)9-BIRTHPLACE,
(State or Country)10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER
(State or Country),12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 14, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
July 14, 1912, to Sept 14, 1922,
that I saw her alive on Sept 14, 1922,
and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis
(Duration) ... yrs. ... 2 mos. ... ds.CONTRIBUTORY
(Secondary)(Duration) ... yrs. ... 2 mos. ... ds.
(Signed) Dr. J. M. ...
Sept 14, 1922 (Address) 712 S. ...*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANS-
FERS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

181922

67642
D 67642

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.,

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 13, 1922, to Sept 18, 1922.

that I last saw him alive on Sept 18, 1922.

and that death occurred, on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis, Congenital

(duration) yrs. mos. 21 ds.

CONTRIBUTORY
(Secondary)

Malnutrition

(duration) yrs. mos. 21 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

9/18, 1922 (Address) 27 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

tion should be carefully supplied. AGE should be stated. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

P18 1922

D 67643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 67643

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

620 S. Montford Ave

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Walter Adamski

(a) RESIDENCE NO.

620 S. Montford Ave

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 21 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Martin Adamski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Josephine Hoffmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Martin Adamski 620 S. Montford Ave

15

Filed Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 8 1922, to Sept. 18 1922

that I last saw ~~live~~ on Sept. 17, 1922

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Gastric Enteritis

(duration) yrs. mos. ds. 10

CONTRIBUTORY Exhaustion

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Ruptured Spleen

(Signed) C. P. Meier, M. D.

(Address) 408 S. Pat PK Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

1903 Rosary Sep 19 1922

20 UNDERTAKER ADDRESS

John M. Weber 1803 Bank

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

181922

Burial Permit Clerk.

D 67644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67644

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Boy Sheridan

(a) RESIDENCE. No.

University Hospital

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 4, 1922*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *University Hospital* (State or country) *Baltimore, Md.*10 NAME OF FATHER *William C. Reuter*11 BIRTHPLACE OF FATHER (city or town) *Baltimore, Md.* (State or country)12 MAIDEN NAME OF MOTHER *Gertrude Sheridan*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md.* (State or country)

14

Informant (Address)

15

Filed *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 15, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Sept. 4*, 19 *22* to *Sept. 15*, 19 *22*, that I last saw him alive on *Sept. 15*, 19 *22*, and that death occurred, on the date stated above, at *6:30 P. m.*

The CAUSE OF DEATH* was as follows:

Chromatury(duration) yrs. mos. *11* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

C. A. Fackler, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*JOHNS HOPKINS HOSPITAL**SEP 16 1922*

20 UNDERTAKER

ADDRESS

Commissioner Health

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

18 1922

Burial Permit Clerk.

D 67645

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital
Eastern Ave.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

CITY OF BALTIMORE: (No. _____)

2-FULL NAME

Joseph Gordon Jr.
Reno, P.O. Northumberland Co. Va.

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)

Male

Colored

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1896

7 AGE

26

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Laborer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Northumberland
County, Virginia

10 NAME OF FATHER

Joseph Gordon Sr.

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Virginia

14

Informant
(Address)

Hospital Records

15

died

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-14 1922

17 I HEREBY CERTIFY, That I attended deceased from
9-7 1922 to 9-14 1922.

that I last saw him alive on 9-14 1922.

and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

CONTRIBUTORY (Secondary) Suppurative Hepatitis
(duration) yrs. mos. 14 ds.
(duration) yrs. mos. 7 ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Yes Date of 9-11-22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Richardson M. D.

19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

UNIVERSITY OF MARYLAND

20 UNDERTAKER

DATE OF BURIAL

ADDRESS 1922
SEP 15 1922Exact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5 If married, widowed, or divorced

(or) WIFE OF

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Exact statement of OCCUPA-

tion should be carefully supplied. AGE should be stated EXACTLY. See instructions on back of certificates.

P 18 1922

Information should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

Md. Gen Hospital

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary Beere

(a) RESIDENCE. NO.

521 Ducker Ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

whit.

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Martin Beere

6 DATE OF BIRTH (month, day, and year)

Oct 31 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45 10 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Daniel Werber

11 BIRTHPLACE OF FATHER (city or town) (State or country)

not known

Germany

12 MAIDEN NAME OF MOTHER

Federica Purmay

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

not known

France

14

Informant (Address)

Hospital Record

15

Filed

Robert F. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/15/22

17

I HEREBY CERTIFY, That I attended deceased from Sept 5, 1922 to Sept 12, 1922 that I last saw her alive on 9/15, 1922, and that death occurred, on the date stated above, at 230P m.

The CAUSE OF DEATH* was as follows:

Toxemia of pregnancy followed by nephritis after delivery several years ago (duration) not known

CONTRIBUTORY

(Secondary)

exact duration (duration)

Yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed)

no symptoms

M. D.

19

(Address)

no Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cemetery

9/19/1922

20 UNDERTAKER

J. A. Moran

ADDRESS

3000 E. Balt. St.

ation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67648

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2602 E Monument ST., WARD 7)

2-FULL NAME Catherine M. Burlin

(a) RESIDENCE NO. 2602 E Monument ST., WARD 7
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 31
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 7th 1911

7 AGE 11 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Charles E. Burlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Catherine French

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Charles E. Burlin (Address) 2602 E Baltimore

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 16, 1922

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1921, to Sept. 16, 1922, that I last saw her alive on Sept. 16, 1922, and that death occurred, on the date stated above, at 8:30 P. M. The CAUSE OF DEATH* was as follows:

Pneumonia (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory test.

(Signed) J. H. Morgan, M. D.

(Address) 1613 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Northwood Cemetery 9/17 1922

20 UNDERTAKER

ADDRESS

J. H. Morgan E. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

67649

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

12 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Day

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to Sept 17, 1922, that I last saw him alive on Sept 16, 1922, and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Phlebotomy

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Premature birth

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

NOVA

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Exact statement of Occurrence should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

P 18 1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67651

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Vincent Inf & Asy* ST. *14 Division St* WARD *1*)

2. FULL NAME

(a) RESIDENCE NO. *14 Division St* ST. *14* WARD *1*
(Usual place of abode)Length of residence in city or town where death occurred yrs. mos. *2* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *May 20 - 22*7 AGE Years Months Days If LESS than 1 day, hrs. or min.
3 *28*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *good*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Glynnville*
(State or country) *md*10 NAME OF FATHER *A. Windsor*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *not known*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *md*14 Informant *St Vincent Inf & Asy*
(Address) *14 Division St*15 Sited *18* 19 *Robert P. Harrison*
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 16* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

, 19 *19*, to *19* *22*.that I last saw him alive on *September 16*, 19 *22*.and that death occurred, on the date stated above, at *11 a* m.

The CAUSE OF DEATH* was as follows:

Malnutrition -
(Hereditary debility)
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Chas. R. Goldstein*, M. D., 19 *22* (Address) *2735 N. Charles St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Mt.

20 UNDERTAKER

Martin Baker Son, 1827 1/2 N. *1827 1/2 N.*

DATE OF BURIAL

Sept 19 19 *22*

ADDRESS

Exact statement of cause of death should be stated on back of certificate. See instructions on back of certificates. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important.

SEP 18 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67652

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 E Heath ST. 24 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 229 E Heath ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Sept 18, 1922, that I last saw him alive on Sept 17, 1922, and that death occurred, on the date stated above, at 7-45 A. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

Signed, R. H. Campbell, M. D.

18, 1922 (Address) 1284 Hancock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Graves Hill Cemetery

9/19/ 1922

20 UNDERTAKER

ADDRESS

E. J. Fanning 1460 Baltimore Ave

B.—WRITE PLAINLY, WITH UNFADING INK.—PHYSICIANS AND STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

SP 18 1922

D 67653

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 67653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

REGISTERED NO.

CITY OF BALTIMORE: (No. FORT MC HENRY, MD. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Wynn,

(a) RESIDENCE No. 812 E. Pratt St., Balto., Md. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male

Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

23

--

--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Record, Ft. McHenry, Md. (Address)

15 SEP 18 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 11, 19 22.

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1921, to Sept. 11, 19 22, that I last saw him alive on Sept. 11, 19 22, and that death occurred, on the date stated above, at 1:57 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease, aortic insufficiency.

CONTRIBUTORY (Secondary) Chr. Valvular heart disease, aortic insufficiency; Pericarditis with effusion.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Report

(Signed) H. D. Harrison, M. D. Surgeon (R) 9/11/22 (Address) U.S. Veterans Hosp. #56, Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

National Cemetery Sept 18, 1922

UNDERTAKER

Sol Harrison & Co. E. Balto. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67654

D 67654

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Cold Spring Lane ST. 11 WARD)

2-FULL NAME Mary Frances Moore Lehr

(a) RESIDENCE. NO. 16 E. Madison ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND

(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17-1834

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/18 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1921, to 9/18 1922, that I last saw him alive on 9/18 1922

and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid flexure

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of op 8/21

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) J. B. Harrison M. D.

9/18 1922 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Burial Permit Clerk

D 67655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D 67655

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4314 Scovell Ave St. 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward J. Briscoe(Residence in Baltimore: No. 4314 Scovell Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, widowed
(Write the word.)6-DATE OF BIRTH, March 31, 1885
(Month) (Day) (Year)7-AGE, 87 yrs. 5 mos. 16 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, retired
(b) General nature of industry, business, or establishment in which employed (or employer), teacher9-BIRTHPLACE, (State or Country), MD.10-NAME OF FATHER, Philip Briscoe11-BIRTHPLACE OF FATHER, (State or Country), MD.12-MAIDEN NAME OF MOTHER, Maria Thompson13-BIRTHPLACE OF MOTHER, (State or Country), MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dorothy G. Crocker(Address) 4314 Scovell Ave

15-SEP 18 1922 Robert F. Harrison

Filed 1922 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 16, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:fracture of pelvis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) accident(Signed) Edmund D. Harrison1922 (Address) 2800 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, (DATE OF BURIAL, Sept 19, 1922)20-EMERALD, Wm. WaldorfADDRESS Wm. Waldorf

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 67656

67656

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2044 76th ST.; 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

mation should be carefully supplied. Exact statement of OCCASION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

P184922

Burial Permit Clerk.

D 67657

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D 67657

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 W Mulberry ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1629 W Mulberry St.; 40 yrs., 5 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Caucasian

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Married

6-DATE OF BIRTH,

Month March 28, 1882
(Month) (Day) (Year)

7-AGE,

40 yrs., 5 mos., 16 ds.If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Laundress
0419-BIRTHPLACE,
(State or Country),

Md

10-NAME OF FATHER,

Thomas Stuart

11-BIRTHPLACE OF FATHER
(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Don't know

13-BIRTHPLACE OF MOTHER
(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Thomas Boone

(Address)

1629 W. Mulberry St.

15-

SEP 19 1922

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 16, 1912
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
1912 to Sept. 16 1912that I saw him alive on Sept. 16 1912and that death occurred, on the date stated above, at 5:10 p.m.

The CAUSE OF DEATH was as follows:

Cardiac Disease
(Valvular)

(Duration).... yrs. mos. ds.

CONTRIBUTORS
(Secondary)

(Duration).... yrs. mos. ds.

(Signed)..... M. D.

Sept. 18 1912 Address)..... 7128 (Mud)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

Sept. 19 1912

20-UNDERTAKER

Brown & Hudson

ADDRESS

114 W. Schoder St.

D 67658 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 Shad alley, ST. 4 WARD)

2-FULL NAME

Maggie King

(a) RESIDENCE. NO.

530 Shad Alley

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female	4 COLOR OR RACE Colored.	5 Single, Married, Widowed, or Divorced (write the word) married
-----------------	-----------------------------	---

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Amos King

6 DATE OF BIRTH (month, day, and year)

December 26 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Clinton
North Carolina

10 NAME OF FATHER

Gabe Moeley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Clinton
North Carolina

12 MAIDEN NAME OF MOTHER

Sarah Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Magnolia
North Carolina

14

Informant
(Address)Lillian Johnson
530 Shad Alley

15

Filed

19

Registrar

SEP 19 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

August 19, 1922, to September 17 1922,

that I last saw her alive on September 9, 1922,

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? auscultation & palpation

(Signed) Chester Riland, M. D.

9-17, 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

M. J. Carter
Daniel E. CarterSept 19 1922
916 Pa Ave

N. B.—Every item of information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67659

CERTIFICATE OF DEATH

3 D 67659

1-PLACE OF DEATH

City of BALTIMORE: (No. #4 Weisenfelt Court Ward 3)

2-FULL NAME

(Residence in Baltimore: No. #4 Weisenfelt Ct St. 5 yrs. 0 mos. 0 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, Female 4-COLOR OR RACE, Black 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Unknown 1. (Month) (Day) (Year)

7-AGE, about 31 If LESS than 1 day, (Month) (Day) (Year) yrs. 0 mos. 0 ds. hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housework (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) Calvert Co, Md

10-NAME OF FATHER, James C. Height

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Maggie Parker

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James C. Height

(Address) Calvert Co, Md

15- Filed SEP 19 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Sept 14 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy, or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy, or Inquiry.) find that said deceased came to death (Cause of death.) topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shoe Factory yrs. mos. ds.

(Signed) Thos B. Fortman Sept 18 1922 (Address) Curtis Bay, Md Coroner.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt Auburn Sept 18 1922

20-UNDERTAKER, ADDRESS John H. Toadum uncl

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67660

D 67660

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2312 Foster ave ST., 1 WARD)

2-FULL NAME

Ethel Mildred Allen

(a) RESIDENCE NO.

2312 Foster ave ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 27 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

420

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Beth

10 NAME OF FATHER

William Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Beth

12 MAIDEN NAME OF MOTHER

Bathume

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Beth

14

Informant (Address)

William Allen2312 Foster ave

15

Filed

SEP 13 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 14 1922 to Sept 16 1922that I last saw him alive on Sept 15 1922and that death occurred, on the date stated above, at 2:30 m.

The CAUSE OF DEATH* was as follows:

Measles(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed)

1922 (Address)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wendell Dyer37 Sma

Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 67661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67661

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 S. Fulton Ave ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Fredonia Rowers(a) RESIDENCE. No. 104 S. Fulton Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 77 Months 2 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Household duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.10 NAME OF FATHER John W. Wall11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Elyzabeth Clark13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Harry Rowers (Address) 104 S. Fulton Ave15 SEP 19 1922 H.A.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 17 192217 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1922, to Sept 16, 1922, that I last saw him alive on Sept 16, 1922, and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Hepatitis (Virus)(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? unknownDid an operation precede death? ✓ Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) E. Heller Heumig M. D.9/17, 1922 Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Olivet Cemetery DATE OF BURIAL Sept 19 1922

20 UNDERTAKER

George J. Smith R. Pyette

tion should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67662

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67662

CERTIFICATE OF DEATH.

31

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Pierce ST., 17 WARD)2. FULL NAME John Saulsbury(a) RESIDENCE NO. 809 Pierce ST., 17 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male4 COLOR OR RACE Colrd5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jun. 18787 AGE 44 Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040(b) General nature of industry, business, or establishment in which employed (or employer) Boat Black(c) Name of employer New Howard Hotel9 BIRTHPLACE (city or town) (State or country) Pennsylvania10 NAME OF FATHER Eli Saulsbury11 BIRTHPLACE OF FATHER (city or town) md

(State or country)

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address) Wife Corine Saulsbury
809 Pierce St

15 191922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 17th 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 1st 1922 to Sept 16th 1922that I last saw him alive on Sept 16th 1922and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis3 mo (duration) yrs. mos. ds.CONTRIBUTORY Cheerful Muscles(Secondary) about 6 mo (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? not knownDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? General Ex of Lung(Signed) John F. Mander M. D.19 (Address) 1002 Edmondson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mt. Auburn Cemetery

DATE OF BURIAL

Sept 20, 1922

20 UNDERTAKER

Mrs Robert A. Elliott Ashland

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67663

CERTIFICATE OF DEATH.

67663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 W Dolph St. 17 WARD)

2-FULL NAME

(a) RESIDENCE. No. 731 W Dolph St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 40. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

I

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

MD

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Rachel Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

Missouri De Mines 731 W Dolph St

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 11, 1922, to Sept 15, 1922

that I last saw him live on Sept 15, 1922,

and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

CONTRIBUTORY

(Secondary)

Chorea Valvulae Aortae

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

19 (Address) 7642 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Saint-Stephen Cemetery Sept 19 1922

20 UNDERTAKER

Baker Bros

ADDRESS 1725

Mrs Robert A Elliott Ashland Ave

SEP 19 1922

Burial Permit Clerk

nation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67664

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3314 Harwood Ct. ST., 76 WARD)

2-FULL NAME

William F. Schultz.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3314 Harwood Ct.

ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 15-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

OOD

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Frank Schultz.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Hellie M. Schlatter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

Frank Schultz.
3314 Harwood Ct.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from

9/15 22, 1922, to 9/18 22, 1922.that I last saw him alive on 9/15 22, 1922.and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Premature Child of
6 1/2 months.
(invariable)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. J. McFarrell
9/19, 1922 (Address) 633-S-3rd St

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Holy Rosary Cem.
Lilly & Geiler.

DATE OF BURIAL

ADDRESS

Sept 19 1922

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67665

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Municipal Hospital

ST., 15 WARD

CITY OF BALTIMORE: (No.)

2-FULL NAME

William H. Dorsey

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred

yrs. mos. ds.

WARD
(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Celtic

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

53

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Balto Co

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant
(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9-14-22

17 I HEREBY CERTIFY, That I attended deceased from
8-29-22, 19 to 9-14-22, 19
that I last saw him alive on 9-14-22, 19
and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

CONTRIBUTORY
(Secondary)(duration) 1 yrs. mos. ds.
Arteriosclerosis
(duration) 5 yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed)

9/18, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL
Joseph H. Dorsey, Balto. Co. Md.

DATE OF BURIAL

Sep 19, 1922

20 UNDERTAKER

JAMES H. DENNIS

1003 PRESTMAN ST.

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

P191922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH **JOHNS HOPKINS HOSPITAL.**CITY OF BALTIMORE: (No. **11** ST., **13** WARD)2-FULL NAME **Marie Sullivan.**(a) RESIDENCE NO. **2314 Etting St. City** ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred **Life** yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **Colored** 5 Single, Married, Widowed, or Divorced, (write the word) **Single.**

5a If married, widowed, or divorced

Benjamin & Carrie Sullivan6 DATE OF BIRTH (month, day, and year) **Aug 14, 1922.**7 AGE Years _____ Months **1** Days **3.** If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work **Child.**

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) **Baltimore,**
(State or country) **Maryland.**10 NAME OF FATHER **Benjamin Sullivan**11 BIRTHPLACE OF FATHER (city or town) **Baltimore,**
(State or country) **Md.**12 MAIDEN NAME OF MOTHER **Carrie Folger.**13 BIRTHPLACE OF MOTHER (city or town) **Balto.**
(State or country) **Md.**14 **JOHNS HOPKINS HOSPITAL**Informant
(Address) **Records.**15 **Robert F. Harlan,**

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **Sept 17 1922**

17 I HEREBY CERTIFY, That I attended deceased from

Sept 12, 1922 to **Sept 17, 1922,**that I last saw her alive on **Sept 17, 1922,**and that death occurred, on the date stated above, at **9:45 P. m.**

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)CONTRIBUTORY (Secondary) **Malnutrition** (duration) yrs. _____ mos. **20** ds.

(duration) yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? **No** Date of _____Was there an autopsy? **No**

What test confirmed diagnosis?

(Signed) **Horton Casparus,** M. D., 19 (Address) **Johns Hopkins Hosp.**

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Mt. Auburn Cemetery

20 UNDERTAKER

JAMES H. DENNIS

DATE OF BURIAL

Sept 20, 1922

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

EP 191922

1003 PRESTMAN ST.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67667

CERTIFICATE OF DEATH.

90 D 67667

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 E. 22nd ST., 12th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Wilhelmina Miller

(a) RESIDENCE NO.

417 E. 22ndST., 12th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 3 mos. 2 ds. How long in U. S., if of foreign birth? 72 yrs. 3 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chas. Wm. Miller

6 DATE OF BIRTH (month, day, and year)

March 23, 1846

7 AGE

76

Years

5

Months

23

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Allendorf, Germany

10 NAME OF FATHER

Christopher Leutner

11 BIRTHPLACE OF FATHER (city or town)

Allendorf

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Christine Muhly

13 BIRTHPLACE OF MOTHER (city or town)

Allendorf

(State or country)

Germany

14

Informant

Fred. W. Miller

(Address)

417 E. 22nd St.

191922

Robert P. 19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 16 1922

17

I HEREBY CERTIFY, That I attended deceased from July 19th, 1922, to Sept 16, 1922, that I last saw her alive on Sept 16th 6:30 A.M., 1922.and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

arterio sclerosis - Mitral insufficiency - an "Chronic Valvular Heart Disease"Insomnia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no

Date of

Was there an autopsy? no

What test confirmed diagnosis?

auscultation - percussion -

(Signed)

Living Miller

M. D.

18, 1922 (Address) 108 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Woodlawn Cemetery Sep 20 1922

20 UNDERTAKER

ADDRESS

Geo. Weber & Son 2503 E. Mondron Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67668

CERTIFICATE OF DEATH.

113 D 67668

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Mc Cullough ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Timothy C. Rice

(a) RESIDENCE NO.

1511 Mc Cullough

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Cal

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Carroll Rice

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

De Laws

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Mrs Rice 1511 Mc Cullough St.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9-18-22

17

I HEREBY CERTIFY, That I attended deceased from 9-9-22, 1922, to 9-18-22, 1922

that I last saw him live on 9-11-22, 1922

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Acute nephritis

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. U. Cardezo, M. D.

(Address) 1524 S. Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Burial Permit Clerk.

D 67669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67669

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *St. Joseph's Hospital* ST. *9* WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Edgemere near Sparrows Point* St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, *single* MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, *Nov 2nd*, 19*16* (Month) (Day) (Year)7-AGE, *5* yrs., *10* mos., ds. IF LESS than 1 day, ...hrs. or...min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work... *Child* (b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE, (State or Country), *Balto. Co.*10-NAME OF FATHER, *Frank H. Boehle*11-BIRTHPLACE OF FATHER (State or Country), *Balto. Md.*12-MAIDEN NAME OF MOTHER *Annie Priety*13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Frank H. Boehle*(Address) *Edgemere near Sparrows Pt.*

15-

Filed

101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 17*, 19*22* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Accidental External Burns**clothing caught fire from burning rubbish* (Duration) *1 hr.* (Time) *10:00 a.m.*CONTRIBUTORY (Secondary) *None*(Signed) *J. H. Vallor* (Coroner.)9-17-1922 (Address) *508 E. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer Cem.* DATE OF BURIAL, *Sept 20*, 19*22*

20-UNDERTAKER

Lilly-Zien

ADDRESS

4008 N. Wolfe

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67670

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67670

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801-41st ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes M. Magee

(a) RESIDENCE. NO. 801-41st ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds.

yrs.

mos.

How long in U. S., If of foreign birth? yrs. mos. ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23-1895

7 AGE

Years 27

Months 3

Days 24

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Edward J. Magee

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Agnes M. Magee

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14

Informant (Address) Edward J. Magee 801-41st ST.

15

SEP 19 1922

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1922

17

I HEREBY CERTIFY, That I attended deceased from June 2, 1922, to Sept 18, 1922

that I last saw him alive on Sept 18, 1922

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) 4 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) 4 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Chas. F. Blumhagen, M. D.

18. 1922 (Address) 504 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral

Sept 21st 1922

20 UNDERTAKER

ADDRESS 517 N. Calvert St.

H. Brannigan

D 67672

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67672

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.

ST.

WARD)

2-FULL NAME

William A. Gerlach

(a) RESIDENCE NO.

518 S. Curley

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Levinson Gerlach

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do

12 MAIDEN NAME OF MOTHER

Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Bay View Hospital

SEP 19 1922

Robert P. Harrison,

Filed

19

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 17, 1922

17

HEREBY CERTIFY, That I attended deceased from

Sept 9, 1922 to Sept 17, 1922

that I last saw him alive on Sept 16, 1922

and that death occurred, on the date stated above, at 12:50 a.m.

The CAUSE OF DEATH* was as follows:

Pneumo-Pneumonia (terminal)

CONTRIBUTORY (Secondary) Acute Myocardial Excitement (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. N. Gledhill, M. D.

9/18/22 (Address) Bay View Hospital

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Carmel

DATE OF BURIAL

Sept 20, 1922

20 UNDERTAKER

Finkler & Finkler

ADDRESS

1739 Eager

D 67673

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67673

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3929 Fernwood ave ST. 16 WARD)

2-FULL NAME

Johanna A. K. G. Schaefer

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

3929 Fernwood ave ST. 16 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

William Schaefer

6 DATE OF BIRTH (month, day, and year) Nov. 4-1876

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

45

10

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

at home

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

John Diedrich

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14

Informant
(Address)William Schaefer
3929 Fernwood ave

15

Filed SEP 19 1922

Robert P. Harrison,

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 16 1922

17

I HEREBY CERTIFY, That I attended deceased from
June 15, 1922, to Sept 16, 1922,
that I last saw him alive on Sept 15, 1922,
and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from
Carcinoma of Stomach.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Carcinoma of stomach

(duration) yrs. 6 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray.

(Signed) C. K. Schaefer, M. D.

7/17, 1922 Address 2937 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Oaklawn Cemetery

DATE OF BURIAL

Sept 19 1922

20 UNDERTAKER

Zirkler + Zirkler

ADDRESS

1739 E. Eager St.

D 67674 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67674

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 S Edwood ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William N Schwatka

(a) RESIDENCE NO. 734 S Edwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Rose P. Schwatka

6 DATE OF BIRTH (month, day, and year) Jan. 7- 1863

7 AGE Years 59 Months 8 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co., Md. (State or country)

10 NAME OF FATHER John A. Schwatka

11 BIRTHPLACE OF FATHER (city or town) Kent Co., Md. (State or country)

12 MAIDEN NAME OF MOTHER Rachel Emily

13 BIRTHPLACE OF MOTHER (city or town) Kent Co., Md. (State or country)

14 Informant Rose P. Schwatka (Address) 734 S. Edwood ST.

15 Filed SEP 19 1922

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1922

17 I HEREBY CERTIFY, That I attended deceased from 1922, to Sept 18th 1922, that I last saw him alive on Sept 17th 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY Exhaustion (Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. J. Russell M. D.

9/18, 1922 (Address) 157 N. Milton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Cemetery

DATE OF BURIAL

Sept 20 1922

20 UNDERTAKER

Gikler + Gikler

ADDRESS

1739 E. Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67675

CERTIFICATE OF DEATH.

44 D 67675

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *654 Portland* ST.; *22* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *654 Portland St* St.; *50* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *Nov. 24th*, 18*47* (Month) (Day) (Year)

7-AGE *74* yrs. *9* mos. ds. If LESS than 1 day,hrs. or....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *House Wife* (b) General nature of industry, business, or establishment in which employed (or employer) *137*

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Fred. Langewitch*

11-BIRTHPLACE OF FATHER (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER *S. Manza*

13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Albert P. M. Seitz*

(Address) *654 Portland St.*

15- *Robert P. Harrison,*

Filed *191* Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 17*, 19*22* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 1* 19*21*, to *Sept 17* 19*22*, that I saw her alive on *Sept 17* 19*22*, and that death occurred, on the date stated above, at *11:15 P.M.*

The CAUSE OF DEATH* was as follows: *Leucosarcoma of the stomach* (Duration) *1* yrs. *11* mos. *16* ds.

CONTRIBUTORY (Secondary) (Duration) *1* yrs. *11* mos. *16* ds.

(Signed) *Harry B. B. M. D.*

1825, 19*22* (Address) *1825*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Western Cemetery* DATE OF BURIAL *Sept. 21st* 19*22*

20-UNDERTAKER *Philip Sewald & Son* ADDRESS *1825*

1825

Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificate.

AP 191922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67676

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 738 W. Lexington ST., 4 WARD)

2-FULL NAME

(a) RESIDENCE NO. 738 W. Lexington ST., 4 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

yrs. 1 mos. 30 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 29, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. 20 or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Melvale Baltimore City

10 NAME OF FATHER

Charles Obman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Minnie Mallory

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va

14

Informant

(Address)

Charles Obman
738 W. Lexington St.

15

Robert P. Harrison,19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 16, 1922, to Sept 19, 1922,that I last saw him alive on Sept 18, 1922,and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus(duration) 1 yrs. 1 mos. 30 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 1 mos. 30 ds.18 Where was disease contracted if not at place of death? 738 W Lexington StDid an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Clinical symptoms(Signed) Chester Riland, M. D.1-19, 1922 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Loudon Park Cem.Sept 20 1922

20 UNDERTAKER

ADDRESS 1044Harry W. Ehlen W. North Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P 191922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67677

HEALTH DEPARTMENT—CITY OF BALTIMORE

67677

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD

2-FULL NAME

Melchior Marczynski

(a) RESIDENCE NO.

1811 Bank

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

18 60

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland Unknown

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Do.

14

Informant (Address)

Bayview Hospital

191922

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1922, to Sept. 18, 1922

that I last saw him alive on Sept. 17, 1922

and that death occurred, on the date stated above, at 3:45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. Gredson M. D.

9/19/22 Address Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

St. Stanislaus Cem., M. J. Sadowski

DATE OF BURIAL

ADDRESS

Sept. 21, 1922 405 S. Ave

1 PLACE OF DEATH

49 City of Baltimore.
STATE OF MARYLAND
CERTIFICATE OF DEATH

County _____

D 62678

Age or City Baltimore. (No. 426 South East Avenue Ward)

Registration Dist. No. _____

2 FULL NAME William Peter Feldpusch. D 67678

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White. 5 ~~SINGLE~~ MARRIED, Married.
(Write the word)

6 DATE OF BIRTH July 15th, 1867.
(Month) (Day) (Year)

7 AGE 55 yrs. 2 mos. 3 ds. IF LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Carpenter. (b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Baltimore, Md.

10 NAME OF FATHER Henry Feldpusch.

11 BIRTHPLACE OF FATHER (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Weicker.

13 BIRTHPLACE OF MOTHER (State or country) Germany.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Bertha Feldpusch.

(Address) 426 South East Avenue.

15 Robert P. Harrison, Registrar

91927

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 18th, 1922.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 30th, 1922, to September 18, 1922, that I last saw him alive on September 18th, 1922, and that death occurred on the date stated above, at 5.25pm. The CAUSE OF DEATH * was as follows:

Malignant papilloma of bladder.

(Duration) 3 yrs. 0 mos. 0 ds.

Contributory Acute pyelo-nephritis, left side.
(Duration) 10 yrs. 0 mos. 0 ds.

(Signed) C. W. S. Rohrer, M. D.

September 18, 1922. (Address) 221 Ailsa Avenue.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 10 yrs. 0 mos. 0 ds. Is the State, 10 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Baltimore Cemetery DATE OF BURIAL Sept. 20, 1922

20 UNDERTAKER Henry Horck ADDRESS 1301 E. Eager St.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67679

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 Valley ST., 10 WARD)

2-FULL NAME

Thomas E. Grogan

(a) RESIDENCE NO.

916 Valley

ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? 22 yrs. 7 mos. 22 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed or divorced

HUSBAND of

Sarah L. Grogan

6 DATE OF BIRTH (month, day, and year)

Jan. 27 1859

7 AGE

63

Years

7

Months

Days

22

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Horse shoe

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Grogan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Mrs. Sarah L. Grogan 916 Valley

15

Filed

Robert E. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1922

17

I HEREBY CERTIFY That I attended deceased from Sept. 19th 1922 to Sept. 19th 1922

that I last saw him alive on Sept. 19th 1922

and that death occurred, on the date stated above, at 12 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. S. Jones, M. D.

(Address) 1501 E. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

DATE OF BURIAL

Sept. 22 1922

20 UNDERTAKER

Henry Woodson

ADDRESS

1301 E. Eager

PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

20.67680 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.67680
D 67680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Retreat St. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rosetta Carroll

(a) RESIDENCE. No. 1502 Retreat St. (Usual place of abode)

ST. WARD. Secreston Md.

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Carroll

6 DATE OF BIRTH (month, day, and year) Jan. 3-1865

7 AGE 59 Years Months 8 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 039

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Alex McCowley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Virginia Buckingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Toller a Maggie (Address) 1502 Retreat St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18-1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 18 1922 to Sept 18 1922

that I last saw him alive on Sept 17 1922

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Inanition (Gradual Starvation)

(duration) yrs. mos. ds. 40

CONTRIBUTORY (Secondary) Carcinoma of esophagus

(duration) yrs. mos. ds. 9

18 Where was disease contracted if not at place of death? Secreston Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Stomach Tube

(Signed) E. E. Nichols, M. D.

(Address) Secreston Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Worton, Kent Co., Md Sept 21 1922

20 UNDERTAKER ADDRESS

Halber H. Shriver 1018 Edmonston Ave

SEP 19 1922

Physicians should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 67681

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *12* WARD)2. FULL NAME *Leila Miser*(a) RESIDENCE NO. *410 Bowen Alley* ST. _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Miser*6 DATE OF BIRTH (month, day, and year) *Aug 16, 1900*7 AGE Years *22* Months *1* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

"House work"

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*West Virginia*10 NAME OF FATHER *Wm. Smith*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*West Va*12 MAIDEN NAME OF MOTHER *Mattie Wilson*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant

(Address)

*Johnnie Miser
512 East Street*

15

SEP 19 1922

Robert P. Harrison,

Registrar

Burial Permit *Clare*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 16 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept 3*, 1922, to *Sept 16*, 1922, that I last saw her alive on *Sept 16*, 1922, and that death occurred, on the date stated above, at *1:30 P* m.

The CAUSE OF DEATH* was as follows:

*Toxic adenoma of the thyroid gland.*CONTRIBUTORY (Secondary) *Shock* (duration) *7* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Sept 16/22*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Daniel J. Pessagno*, M. D.
(Address) *Mary Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Int. Auburn Cem**9/20/22*

20 UNDERTAKER

Jas. M. Skinner 16250 Mad. St.

PHYSICIANS should state EXACTLY. Exact statement of OCCASION. AGE should be carefully supplied. AGE should be properly classified, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67682

CERTIFICATE OF DEATH.

90 D 67682

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 East ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME India Jackson(a) RESIDENCE. (Usual place of abode) 512 East St ST.: 5 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) Widow5a If married, widowed, or divorced HUSBAND of not known (or) WIFE of6 DATE OF BIRTH (month, day, and year) Unknown7 AGE 50 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Minnie Darsen (Address) 512 East St15 Signed Robert P. Harrison Registrar

SEP 19 1922

Burial Permit 4147

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-17- 19 22

17

I HEREBY CERTIFY, That I attended deceased from Aug 25, 1922, to Sept 17, 1922, that I last saw her alive on Sept 17, 1922, and that death occurred, on the date stated above, at 1-15 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas M. D.9-18, 1922 Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cem9/21/22 19 22
ADDRESS

20 UNDERTAKER

Jas. M. Skinner 1625 E. Mad. St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67683

90 D 67683

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Municipal Hospital 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.,

WARD)

2-FULL NAME

Elizabeth Jack

(a) RESIDENCE NO.

815 1/2 E. Pratt St.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

55

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

55

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

#

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Herman Jack

6 DATE OF BIRTH (month, day, and year)

July 20, 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

24

1

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Corp. Reed & Co.

15

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/16/22

17

I HEREBY CERTIFY. That I attended deceased from

3-27-1922, to

9-16-22

that I last saw him alive on

9-16-22

and that death occurred, on the date stated above, at

4:56 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

CONTRIBUTORY (Secondary)

Heart

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

(Signed)

Clyde M. Hall, M. D.

9/1/22 (Address)

Munroe Corp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Schwartz's Cem

DATE OF BURIAL

Sept 20 1922

20 UNDERTAKER

Mr. Mrs. John W. Kaufel & Son

ADDRESS

801 W. Fayette

Physicians should state EXACTLY. Exact statement of OCCASION. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCASION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

191922

Burial Permit Class.

D 67684

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67684

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S. Bond ST. 2 WARD)

2-FULL NAME

Wladyslaw Zdzumowski

(a) RESIDENCE NO.

617 S BondST. 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (Write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 27-1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1720

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

Wladaw Zdzumowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Mary Marykowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Mary Zdzumowski
617 S Bond

15

Filed Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 12 1922 to Sept 15 1922 that I last saw h^e alive on Sept 12 1922 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Buteo Colitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis

(Signed)

Sept 18 1922

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

William Fralickowski 1618 Eastern
av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 156551
D 67685) JOHNS HOPKINS HOSPITAL, ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Martin Tomulatis

(a) RESIDENCE NO.

Andrea, W. Va.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male. White Married.

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Mary Tomulatis (wife),
1884.

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.38??

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Spinor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Russia.

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country)Unknown

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Unknown

14

Informant
(Address)JOHNS HOPKINS HOSPITAL.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 17, 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 14, 1922, to Sept 17, 1922.that I last saw him alive on Sept 17, 1922.and that death occurred, on the date stated above, at 250 P. m.

The CAUSE OF DEATH* was as follows:

Blastomycosis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?Henry West Va

Did an operation precede death?

Yes Date of June 20, 1922

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

Lucile Holman, M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Henry W. W. ASept 19, 1922

20 UNDERTAKER

ADDRESS

Joseph W. W. A2211 B. Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

P 191922

Burial Permit Clerk.

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67686

CERTIFICATE OF DEATH.

90 D 67686

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Bailey

(a) RESIDENCE No. 1506 Presstman St. ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 18 72

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 50 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co., Maryland (State or country)

10 NAME OF FATHER Edgar Matthews

11 BIRTHPLACE OF FATHER (city or town) Harford Co., Maryland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Harford Co., Maryland (State or country)

14 Informant Hospital Records, Municipal Hospital. (Address)

15 Filed SEP 20 1922 ROBERT R. KRAUTER, Registrar Social Permit State

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16 1922 to Sept. 18 1922, that I last saw her alive on September 18, 1922, and that death occurred, on the date stated above, at 12:30 P.M. The CAUSE OF DEATH* was as follows:

Myocardial degeneration (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? (Signed) Clyde W. Neal M. D.

9/19 1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
NOVA
Int. Auburn

DATE OF BURIAL

Sept 20 1922

20 UNDERTAKER

John H. Toadum

ADDRESS

unfiled

N. B.—WRITE IN INK, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 67687 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67687

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE No. 1025 Plunial ST. 23 WARD

2-FULL NAME

John Bacon

(a) RESIDENCE. No.

1025 Plunial ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

59 yrs. 3 mos. 10 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Calais 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Bacon

6 DATE OF BIRTH (month, day, and year) 12/28/1862

7 AGE Years 59 Months 3 Days 10 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Lumberman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

Pease Bacon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind

12 MAIDEN NAME OF MOTHER

Maryann

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind

14 Informant (Address)

Lydia Bacon 1025 Plunial

15 SEP 20 1922

ROBERT R. KRAUTER Registrar

Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) 9/18/22

17 I HEREBY CERTIFY, That I attended deceased from 8/22/22 to 9/18/22 that I last saw him alive on 9/18/22 and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Heart Regurgitation and subacute Nephritis

CONTRIBUTORY (Secondary) Cor. Arteriosclerosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical microscopy

(Signed) F. J. B. M. D.

19 (Address) 908 S. Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

West Auburn Sept 20 1922

20 UNDERTAKER ADDRESS 142

John H. Toadum W. Steel St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D 67688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1623 E Eager ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 6 mos. 14 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19 1922

17. I HEREBY CERTIFY, That I attended deceased from
Sept 4, 1922, to Sept 14, 1922
that I last saw her alive on Sept 19, 1922

and that death occurred, on the date stated above, at 2:40 p.m.

The CAUSE OF DEATH* was as follows:

Gastro-Euterisides

(duration) yrs. 10 mos. ds

CONTRIBUTORY
(Secondary)

..... (duration) yrs. mos. ds

18 Where was disease contracted _____
if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? ELISA

(Signed) _____ M.N.

19 (Address) *9800 Avenue*

*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
--------------------------------------	----------------

MOVIE
New Cathedral Cemetery Sept 28 192

20 UNDERTAKER	ADDRESS
---------------	---------

Lenny Hochstad 13012 Bagot.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67689

67689

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *115 Y. Duncan* ST., *6* WARD)

2. FULL NAME

Rose Bernat

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

*117 Y. Duncan*ST., *6* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., if of foreign birth? *32* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Joseph Bernat*6 DATE OF BIRTH (month, day, and year) *June 20 1860*7 AGE *62* Years *2* Months *28* Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bohemia

10 NAME OF FATHER

John Plachy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Annie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

14

Informant (Address)

Joseph Bernat 117 Y. Duncan St.

15

SEP 20 1922

ROBERT R. KRAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 18 1922*

17 I HEREBY CERTIFY, that I attended deceased from

June 1, 19*22*, to *Sept 18*, 19*22*.that I last saw her alive on *Sept 18*, 19*22*.and that death occurred, on the date stated above, at *4 P.* m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis

CONTRIBUTORY (Secondary)

Myocardial insufficiency

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Edward Swack*, M. D., 19 (Address) *821 N. Pratt St. Av.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Oak Hill Cem. *Sept 21 1922*

20 UNDERTAKER

Philips Stewig

DATE OF BURIAL

ADDRESS

2016 Calver

N. B.—WRITERS OF THIS FORM SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. EXACT STATEMENT OF OCCUPATION SHOULD BE CAREFULLY SUPPLIED. EXACT STATEMENT OF OCCUPATION SHOULD BE CAREFULLY SUPPLIED. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67690

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square ST., 18 WARD)

2-FULL NAME

E. Elizabeth Whitworth

(a) RESIDENCE NO.

1000 N. Franklin

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

81 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1841

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80 10 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Richard Whitworth

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Susan Grant

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Harford Co Md

14

Informant (Address)

Mrs E. Clark Dick
626 N. Fulton Ave

15

Filed

SEP 20 1922 ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

SEP 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 2nd, 1922, to Sept 19th, 1922,
that I last saw him alive on Sept 17th, 1922,
and that death occurred, on the date stated above, at 5-10 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

CONTRIBUTORY (Secondary)

5 days (duration) yrs. mos. ds.age 80 (duration) yrs. 18 mos. ds.18 Where was disease contracted if not at place of death? Baltimore CityDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) H. F. Hill, M. D.19 (Address) 1208 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Western
Geo W Little

DATE OF BURIAL

SEP 20 1922

ADDRESS

EDMONSON AVE.

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4608 Eastern Ave. ST., 16 WARD)

2-FULL NAME Clifford Terrell Schumann

(a) RESIDENCE NO. 4608 Eastern Ave. ST. 10 WARD 10
(Usual place of abode) (If none)

Length of residence in city or town where death occurred 1 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
-------	-----------------	--

male White

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21, 1922

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
		2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) **Name of employer:**

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER *Alfred F. Schuman*

11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Belgium*

12 MAIDEN NAME OF MOTHER *Julia Terrell*

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

24 Informant Julia Schumann
(Address) 4638 Eastern Ave.

15
Filed: SEP 20 1968 ROBERT B. WINTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/19/2022

17 I HEREBY CERTIFY, That I attended deceased from
Sept 18, 1922, to Sept 19, 1922.

that I last saw him alive on Sept 19, 1922

and that death occurred, on the date stated above, at 4 15 A. m

The CAUSE OF DEATH* was as follows:

Broacho pneumonia

(duration) yrs. mos. 2 da

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death?.....Date of.....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tok M. D.

10. (Address) 1470 E. Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
---	----------------

Baltimore Cemetery Sept 21 1921

70 UNDERTAKER	/ ADDRESS
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✓ Wanderer Song 17107 Feb

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

OFFICE HOURS:
11 TO 12 M.
6 TO 7.30 P. M.

DR. ADAM A. TOD
2935 EASTERN AVE.
PHONE, WOLFE 2751

REG. No. 2969
4704 EASTERN AVE.
PHONE, WOLFE 4963

OFFICE HOURS: 10 TO 11 A. M. & 8 TO 9.30 P. M.

NAME ADDRESS

B

*Age 2 child
Schuman
Born May 21st
1922
Adam Tod.*

SIGNED

DATE

ADVANCE PHARMACY
1411 E. 14TH STREET
CIVIL EASTERN AVENUE AND 14TH STREET

"Epidemic cerebrospinal meningitis"; *typhoid fever* (never report "Typhoid pneumonia"); *lobar pneumonia*; *bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *tuberculosis of lungs*, *meninges*, *pertussis*, etc., *carcinoma*, *sarcoma*, etc., of *any* organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No infection found.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

160 D 67692

1-PLACE OF DEATH

St Vincent's Inf Asy

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1401—Division

ST., 14 WARD)

2-FULL NAME

Frances Barge

(a) RESIDENCE NO.

1401—Division

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

May 28-22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Charles Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Gertrude Barge

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

St Vincent Inf Asy 1401 Division St.

15

SEP 20 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 13, 1922, to Sept. 16, 1922, that I last saw her alive on Sept 16, 1922

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Malnutrition (chronic debility)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. R. Goldborough M. D.

19 (Address) 2735 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cem

Sept 20, 1922

20 UNDERTAKER

ADDRESS

M. F. Kelly & Son

137 W. North

PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Ruskin Ave ST. 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen F. Schwertae(Residence in Baltimore: No. 2311 Ruskin Ave St. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow

6-DATE OF BIRTH,

Canada

(Month)

(Day)

(Year) 1874

7-AGE,

75

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country),

Canada

PARENTS.

10-NAME OF FATHER,

Matthew Schaugnessy

11-BIRTHPLACE OF FATHER, (State or Country),

Irish

12-MAIDEN NAME OF MOTHER

D Sullivan

13-BIRTHPLACE OF MOTHER, (State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Schwartz(Address) 2311 Ruskin Ave

15-

Filed

191

SEP 20 1922

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

18

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 1 1912 to Sept 18 1922,

that I saw him alive on Sept 18 1922,

and that death occurred, on the date stated above, at 6 P.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) Dr. J. J. Schaub M. D.

9/20/1922 (Address) 2724 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lorraine Cemetery

Sept 24, 1922

20-UNDERTAKER

ADDRESS

Martin Kelly, Son

837 80 North Ave

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67694

D 67694

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 ST.: 13 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 3714 Roland Ave. ST.: WARD.

(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Edith Belt

6 DATE OF BIRTH (month, day, and year) Mar. 12/1885

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

67

6

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Co. Md.

10 NAME OF FATHER

John Cross

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Co. Md.

12 MAIDEN NAME OF MOTHER

Erdman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Canell. Co. Md.

14 Informant (Address)

Mr. G. J. Belt
4117 Fall Rd.

SEP 20 1922

N. A. Marshall Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-15 1922

17 HEREBY CERTIFY, That I attended deceased from Aug 28, 1922, to Sept 15, 1922, that I last saw her or alive on Sept-16, 1922, and that death occurred, on the date stated above, at 11:20 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

CONTRIBUTORY (Secondary)

Arterio Sclerosis + Chronic Nephritis

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys. N. Sept 18 1922

20 UNDERTAKER

A. S. Marshall 3539 Fall Rd.

D 67695 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67695

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 310 N Broadway ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 310 N Broadway

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, / hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

SEP 20 1922

ROBERT H. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 18, 1922, to Sept 18, 1922

that I last saw her alive on " " 1922

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Edema of lungs
Breath Arrest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. H. M. D.

19. 1922 Address 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

Sept 20 1922

20 UNDERTAKER

ADDRESS

Joseph Ahrens

221 Buoy

Information should be carefully supplied. AGE should be stated EXACTLY. Informant should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67696 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67696

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *619 S. Bethel St.* Ward) *161-001*

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *619 S. Bethel St.* St.; yrs.,..... mos..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Single*
(Write the word.)6-DATE OF BIRTH, *Sept 18*, 19*22*
(Month) (Day) (Year)7-AGE, *2* yrs.,..... mos..... ds. If LESS than 1 day,..... hrs. or..... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE,
(State or Country), *Poland*PARENTS:
10-NAME OF FATHER, *Wladyslaw Kasprzyk*
11-BIRTHPLACE OF FATHER, *Poland*
(State or Country),
12-MAIDEN NAME OF MOTHER, *Mary Brulund*
13-BIRTHPLACE OF MOTHER, *Poland*
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *W. Kasprzyk*
(Address) *619 S. Bethel*15
SEP 20 1922
Filed 1922Registrar, *Haw*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 19*, 19*22*
(Month) (Day) (Year)17- I HEREBY CERTIFY That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
find that said deceased came to..... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxiation -
Malnutrition
(Duration)..... yrs..... mos..... ds.CONTRIBUTORY (Secondary).....
(Signed)..... M. D.
(Coroner.)
(Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

John Rosary *Sept 20, 1922*
20-UNDERTAKER, ADDRESS
W. Galkowski *1618 Easte*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. 3—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67697 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *2376 Bradford* St. *6* Ward)

2-FULL NAME

(Residence in Baltimore: No. *2376 Bradford* St.; yrs. mos. ds.)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-Single, Married, Widowed, or Divorced, (Write the word.) *Infant*

6-DATE OF BIRTH,

June 5 19*22*
(Month) (Day) (Year)

7-AGE,

yrs. *4* mos. *14* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9-BIRTHPLACE, (State or Country),

Baltimore Maryland

10-NAME OF FATHER,

John Behrens

11-BIRTHPLACE OF FATHER, (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER,

Rosal Harris

13-BIRTHPLACE OF MOTHER, (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Rosal Harris*

(Address) *2376 Bradford St.*

SEP 20 1922

ROBERT R. MAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 19 19*22*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *Inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Inquest* (Inquest, au-

topsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap. Bronchitis

(Duration) yrs. *17* ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. *17* mos. *14* ds.

(Signed) *Robert R. Mauter* M. D. (Coroner.)

1922 (Address) *2376 Bradford St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mount Carmel

Sept 20 19*22*

20-UNDERTAKER,

ADDRESS

Wendell J. Lippert

37 Lane St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67698

CERTIFICATE OF DEATH.

174 67698

1-PLACE OF DEATH

City of BALTIMORE: (No. 1524 West Laval St. Ward 16)

Registered No. C.....

2-FULL NAME

Rachel R. Goodman

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1524 West Laval St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Single6-DATE OF BIRTH, Jan 1, 1884 (Month) (Day) (Year)7-AGE 68 yrs. 9 mos. 17 ds. If LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, At Home (b) General nature of industry, business, or establishment in which employed (or employer) god9-BIRTHPLACE, (State or Country), Annapolis Md10-NAME OF FATHER, Dr Wm R. Goodman11-BIRTHPLACE OF FATHER, (State or Country), Maryland12-MAIDEN NAME OF MOTHER, Rebecca Richardson13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. B. Goodman(Address) 1524 W. Laval

15-SEP 20 1922 Filed 1922

ROBERT A. KNAUER

Registrar.

Burial Permit Clerk

Lor Hemmery

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 15, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ch. Interstitial Nephritis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) cardiac

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Hemmery, M. D. (Coroner.)(Address) 202 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Landon Park Sept 21, 1922

20-UNDERTAKER, ADDRESS

Wm Cook 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67699

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 832 N. Fayette St. St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edna M. Spear

(Residence in Baltimore: No. 832 N. Fayette St. St. 18 yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, Married
(Write the word.)

6-DATE OF BIRTH, Feb. 10, 1893
(Month) (Day) (Year)

7-AGE, 29 yrs. 7 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, House wife
(b) General nature of industry, business, or establishment in which employed (or employer), 037

9-BIRTHPLACE, (State or Country), Mo'

PARENTS.
10-NAME OF FATHER, Mr. School
11-BIRTHPLACE OF FATHER, (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Dora Kline
13-BIRTHPLACE OF MOTHER, (State or Country), Illinois

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herbert N. Spear
(Address) 832 N. Fayette St.

15-SEP 20 1922
Filed 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 19, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gas Inhalation
(Duration) a few hrs yrs. mos. ds.

CONTRIBUTORY Suicide
(Secondary) (Duration) yrs. mos. ds.
(Signed) H. H. G. G. G. M. D.
(Coroner) 9-20, 1922 (Address) 117 N. Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery DATE OF BURIAL, Sept 22, 1922
20-UNDERTAKER, Mr. Cook ADDRESS, 502 E. North ave.

D 67700 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17) Municipal Tuberculosis Hospital WARD

2-FULL NAME Emma Barnes

(a) RESIDENCE No. 527 Fremont ave.

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred Unknown mos.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Not given

6 DATE OF BIRTH (month, day, and year) 1896 ?

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

26 ?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER John Coates

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER Maggie Snowden

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant Hospital Records (Address)

15

SEP 20 1922 ROBERT R. ANSTON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1922, to Sept. 18, 1922.

that I last saw her alive on Sept. 18, 1922.

and that death occurred, on the date stated above, at 4.10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum X-ray

(Signed) Francis L. Gadsden, M. D.

9-19-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-BURIAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67701

CERTIFICATE OF DEATH.

B 67701

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 764 Ramsey ST., 21 WARD)

2-FULL NAME

Mary E. Crotty

(a) RESIDENCE NO.

764 Ramsey

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofGeorge P. Crotty

6 DATE OF BIRTH (month, day, and year)

Feb 19 18 91

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.55630

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workHousework(b) General nature of industry,
business, or establishment in
which employed (or employer)at Home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto.md.

10 NAME OF FATHER

Stephen McGowan11 BIRTHPLACE OF FATHER (city or town)
(State or country)Ireland

12 MAIDEN NAME OF MOTHER

Mary O'Hara13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Ireland

14

Informant
(Address)Mrs. Jane Dignan (Sister)
1000 S. Paca St

15

SEP 20 1922

ROBERT R. KRAUSE Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 18 19 2217 I HEREBY CERTIFY, That I attended deceased from
Sept - 11, 19 22, to Sept - 18, 19 22
that I last saw him alive on Sept - 18, 19 22and that death occurred, on the date stated above, at 28 m.

The CAUSE OF DEATH* was as follows:

ApoplexyCONTRIBUTORY
(Secondary)(duration) yrs. mos. 1 ds.(duration) yrs. mos. 15 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Chlorine(Signed) M. C. Trilling M. D.(Address) 682 Washington Blvd*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVALCathedral Cemetery

DATE OF BURIAL

Sept 21 19 22

20 UNDERTAKER

James Dignan & Son

ADDRESS

1000 S. Paca St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67702

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3137 Eastern Ave. ST., 1 WARD)

2-FULL NAME

Andrew A. Weinkam

(a) RESIDENCE NO.

3137 Eastern Ave. ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary Weinkam

6 DATE OF BIRTH (month, day, and year)

Aug 19-1855

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

67

0

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stationary 030

(b) General nature of industry, business, or establishment in which employed (or employer)

Engineer

(c) Name of employer

Continental Can Co.

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Andrew Weinkam

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germ any

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germ any

14

Informant

(Address)

Mary Weinkam
3137 Eastern Ave.

15

Filed

SEP 20 1922

ROBERT A. KRAUER

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Mar 3, 1922 to Sep 18, 1922.

that I last saw him alive on Sep 18, 1922.

and that death occurred, on the date stated above, at 4:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Yes Johns Hopkins
Hospital

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. H. Moore M. D.

, 19

(Address)

3015 Ellwood Ave

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cem

DATE OF BURIAL

Sept. 21 1922

20 UNDERTAKER

Lily and Zeiler

ADDRESS

4038 Stoll

D 67704

HEALTH DEPARTMENT CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 E. Chase St. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 1 hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

SEP 20 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-19 1922

17

I HEREBY CERTIFY, That I attended deceased from

9-19 1922, to 9-19 1922,

that I last saw her alive on 9-19 1922,

and that death occurred, on the date stated above, at 9.30 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

A. 22

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67705

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.

2-FULL NAME

(Residence in Baltimore: No.

ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and Hill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Robert F. Harrison,

Filed

1912

Marial Peralt Clark.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) M. D. (Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. Since yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

PUBLIC CEMETERY.

DATE OF BURIAL,

....., 19...

20-UNDERTAKER

ADDRESS

THE MORGUE.

SEP 2 1912

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67706

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 516 Poplar Grove ST. 20 WARD)

2-FULL NAME

(Residence in Baltimore: No. 516 Poplar Grove St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, 12 hrs.,
yrs. mos. ds. or min.?

8-OCCUPATION

(a) Trade, profession or
particular kind of work
(b) General nature of industry,
business, or establishment in
which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF
FATHER

11-BIRTHPLACE
OF FATHER
(State or country)

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed) Frank N. Hillis M. D.
1922 [Address] 2838 E. Howard St.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER
Commissioner Health,

ADDRESS

SEP 20 1922

Burial Permit Clerk

REGISTRAR

JOHNS HOPKINS HOSPITAL

For Wm. F. Woodall

SEP 20 1922

N. B.—Every item of information should be carefully supplied. AGE SHOULD BE STATED EXACTLY. PHYSICAL CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. See instructions on back of certificate.

(Bibby)

D 67707 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67707

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1514 N. Dallas St., 8 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Annie Bibby

(Residence in Baltimore: No. 1514 N. Dallas St.; 5 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Black 5-Single, Married, Widowed, or Divorced, Married (Write the word.)

6-DATE OF BIRTH, July 22, 1886 (Month) (Day) (Year)

7-AGE, 36 yrs., 6 mos., 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laundress (b) General nature of industry, business, or establishment in which employed (or employer), 04

9-BIRTHPLACE, (State or Country), St Marys Co Md

PARENTS. 10-NAME OF FATHER, Henry Bibby 11-BIRTHPLACE OF FATHER, (State or Country), Kentucky 12-MAIDEN NAME OF MOTHER, Catharine Wood 13-BIRTHPLACE OF MOTHER, (State or Country), St Marys Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Catharine Wood (Address).....

15- Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Heart Disease (Dr. Green reports Valvular Insufficiency) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) J. D. Hall M. D. (Coroner.) Sept 16 1922 (Address) 505 E. North St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?.....

Former or usual residence..... 19-PLACE OF BURIAL OR REMOVAL, South Cemetery DATE OF BURIAL, Sept 21, 1922 20-UNDERTAKER, Edward Bryan ADDRESS Chesapeake St

PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67708

38 D 67708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No.

ST.

WARD

2-FULL NAME

Parson Lemquist

(a) RESIDENCE No.

1060 Pine

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Former

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pa

12 MAIDEN NAME OF MOTHER

Pa

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Bay View Hospital

15

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 20, 1922

17 I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1921, to Sept 20, 1922.

that I last saw him alive on Sept 19, 1922.

and that death occurred, on the date stated above, at 5:50 a. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Arteries)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

9/20/22 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVES

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Laurel Cemetery

9-22-1922

EP 20 1922

Burial Permit

D 67709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-6 67709
27
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5145 Park Heights Ave.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary M. Bridge

(Residence in Baltimore: No. 5145 Park Heights Ave.; 28 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *fm.* 4-COLOR OR RACE, *white* 5-STATUS, *widow*
(Write the word.)6-DATE OF BIRTH, *June 18, 1883*
(Month) (Day) (Year)7-AGE, *29 yrs. 6 mos. 2 ds.* If LESS than 1 day, ...hrs. or...min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *no paid occupation*
(b) General nature of industry, business, or establishment in which employed (or employer) *000*9-BIRTHPLACE, (State or Country), *Ind.*PARENTS.
10-NAME OF FATHER, *Martin Wroten*
11-BIRTHPLACE OF FATHER (State or Country), *Ind.*
12-MAIDEN NAME OF MOTHER *Mary R. Cantk*
13-BIRTHPLACE OF MOTHER (State or Country), *Ind.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *S. O. Bridges*(Address) *5145 Park Heights Ave.*

15-

Robert P. Harrison,

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 20, 1922*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *Sept. 13, 1922*, to *Sept. 20, 1922*, that I saw him alive on *Sept. 19, 1922*, and that death occurred, on the date stated above, at *6 a.m.*

The CAUSE OF DEATH* was as follows:

Hemiplegia
(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Signed) *J. J. Sherman* M. D.
Sept. 20, 1922 (Address) *2226 Madison St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,
GREENMOUNT CEMETERY *SEPT. 27, 1922*20-UNDERTAKER ADDRESS
H.E. HUGHES *424 N. BROADWAY*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

20 1922

158423
D 67710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67710

1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

2. FULL NAME

Mrs. Rebecca Strauss.

(a) RESIDENCE NO.

305 S. Cedar St. Marshfield, Wisconsin.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White.

Married

5a If married, widowed, or divorced

(or) WIFE of

Dr. Richard J. Strauss (HUSBAND)

6 DATE OF BIRTH (month, day, and year)

April 4, 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

5

16.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New Orleans

La.

10 NAME OF FATHER

Jacob. Shapiro.

11 BIRTHPLACE OF FATHER (city or town)

Europe

12 MAIDEN NAME OF MOTHER

Delphine Frank.

13 BIRTHPLACE OF MOTHER (city or town)

Paris

(State or country)

France

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

Robert T. Harrison

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1922, to Sept 20, 1922.

that I last saw her alive on Sept 20, 1922.

and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Brain tumor, right cerebellar

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

At home in Wis.

Did an operation precede death?

No Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

D. L. Reichert

M. D.

9/20, 22 Address

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

MOUNTAIN VIEW, BALTIMORE

Sept 20 1922

20 UNDERTAKER

ADDRESS

Joseph D. Cook

103 N. Balto St.

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 20 1922

D 67711

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67711

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 Penrose Ave. ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Drayton Pope Jr.

(a) RESIDENCE NO. 1801 Penrose Ave.

(Usual place of abode)

ST.

WARD

Jacksonville Fla.

Length of residence in city or town where death occurred 14 days

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 30th 1907

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

14

8

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Jacksonville (State or country) Fla.

10 NAME OF FATHER Thomas Drayton Pope

11 BIRTHPLACE OF FATHER (city or town) Columbia (State or country) S. C.

12 MAIDEN NAME OF MOTHER Cora L. Roughton

13 BIRTHPLACE OF MOTHER (city or town) Sandersville (State or country) Ga.

14 Informant D. C. Mc Kim (Address) 1802 Penrose Ave.

15 Robert F. Harrison, Registrar

Burial Permit No. 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept. 18, 1922, to Sept. 20, 1922.

that I last saw him alive on Sept. 20, 1922

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY Intestinal obstruction (Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

E. J. Dickey, M. D.

14 N. Monroe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Joseph B. Cook 1003 N. Leno St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVENS FROM THE INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EP 201922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

PLACE OF DEATH

CITY OF BALTIMORE (No. 610 E. Pratt St.

ST. 4 WARD)

FULL NAME

(Residence in Baltimore: No. Rick Hall - Md

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

It LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP 21 1922

101

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Insanity by self-harm

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner.)

M. D.

(Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

D 67713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *17 N Durlan* ST.: *6* WARD)

2-FULL NAME

(a) RESIDENCE. No. *17 N Durlan* ST.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 22/1922

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

*6**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore*

10 NAME OF FATHER

*John Hopkins*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Md.*

12 MAIDEN NAME OF MOTHER

*Rose Hudson*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Baltimore*

14

Informant
(Address)*John Hopkins*

15

Filed

*ROBERT R. KRAUTER**17 N Durlan St**Registral**Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 18 1922

17.

I HEREBY CERTIFY, That I attended deceased from

*Sept 17 1922, to Sept 19 1922.*that I last saw her alive on *Sept 18 1922*and that death occurred, on the date stated above, at *1 P.* m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)*Convulsions*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

None of these

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

General diagnosis

(Signed)

Alfred C. Eiden M. D.

19.

Address *2201-03 Orleans St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer**Sept 20 1922*

20 UNDERTAKER

Paul Erickson

ADDRESS

1906 1/2 Howard

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 67714 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 St. Paul ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Lynch

(a) RESIDENCE NO. 1604 St. Paul

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1860

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

62 8 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Va. (State or country)

10 NAME OF FATHER James Lynch

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary O'Brien

13 BIRTHPLACE OF MOTHER (city or town) Richmond Va. (State or country)

14 Informant Mrs. A. M. Brownell (Address) 1604 St. Paul Street

15 SEP 21 1922 ROBERT R. MAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 18 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1922 to Sept 18 1922, that I last saw him alive on Sept 18 1922, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Recurrent Carcinoma left side following radical operation for cancer left breast 5 years ago

CONTRIBUTORY this left condition (Secondary) about 18 months preceding

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. J. Kirby, M. D.

Sept 19 22 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cemetery

DATE OF BURIAL

9/21, 1922

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67715

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *243 Nelson St.* St. *14* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Walter W. Barnes

(Residence in Baltimore: No. *243 Nelson St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, (Write the word.) *single*

6-DATE OF BIRTH, *about 9:00* (Month) (Day) (Year)

7-AGE, *about 22* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *stenographer* (b) General nature of industry, business, or establishment in which employed (or employer). *086*

9-BIRTHPLACE, (State or Country), *Balto. Md.*

PARENTS 10-NAME OF FATHER, *W. H. ...* 11-BIRTHPLACE OF FATHER, (State or Country), *...* 12-MAIDEN NAME OF MOTHER, *...* 13-BIRTHPLACE OF MOTHER, (State or Country), *...*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Geo. Mosssett* (Address) *1442 N. Gay St.*

15-Filed *SEP 21 1922* ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 19* 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) held that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Angina Pectoris* *Probably induced death* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *no history* (Duration) yrs. mos. ds. (Signed) *J. H. ...* M. D. (Coroner) *Sept 20 1922* (Address) *280 E. ...*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Parkwood cemetery* DATE OF BURIAL, *Sept 21 1922*

20-UNDERTAKER, *Geo. Mosssett* ADDRESS *1442 N. Gay St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67716

CERTIFICATE OF DEATH.

D 67716

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2020 Malbrook Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mellie Virginia Burgom.(a) RESIDENCE. NO. 2020 Malbrook Ave. ST. _____ WARD _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

Norman Burgom.6 DATE OF BIRTH (month, day, and year) March 4, 18987 AGE Years Months Days If LESS than 1 day, hrs. or min.
24 6 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) Martinsburg, W. Va.
(State or country)10 NAME OF FATHER Aaron M. Ricker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Penna.12 MAIDEN NAME OF MOTHER Sara B. McQuilkin13 BIRTHPLACE OF MOTHER (city or town) Martinsburg, W. Va.
(State or country)14 Informant Norman Burgom(Address) 2020 Malbrook Ave.15 SEP 24 1922 ROBERT R. KROGER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20, 192217 I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1922, to Sept. 19, 1922, that I last saw her alive on Sept. 19, 1922, and that death occurred, on the date stated above, at 12" P. M.
The CAUSE OF DEATH* was as follows:Acute pericarditis(duration) _____ yrs. _____ mos. 3 ds.CONTRIBUTORY Acute articular rheumatism
(Secondary)(duration) _____ yrs. _____ mos. 15 ds.18 Where was disease contracted if not at place of death? 2020 Malbrook Ave.Did an operation precede death? No Date of _____Was there an autopsy? "What test confirmed diagnosis? Examination(Signed) John D. Quinn, M. D.9/20, 1922 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge Cem 9/22 1922

20 UNDERTAKER ADDRESS

J. F. Mc Gully 130 E. Fort

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Lancaster ST., V WARD)

2-FULL NAME

Stanislawo Rydzewski

(a) RESIDENCE NO.

1809 Lancaster ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21-19247 AGE Years 1 Months 5 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

MD10 NAME OF FATHER Stanislaw Rydzewski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland12 MAIDEN NAME OF MOTHER Teresa Grela

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland14 Informant St. Rydzewski (Address) 1809 Lancaster

15 SEP 21 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 192217 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1922, to Sept 20, 1922, that I last saw him alive on Sept 20, 1922, and that death occurred, on the date stated above, at 5 A. m. The CAUSE OF DEATH* was as follows:Enteric Colitis(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William G. Ryan, M. D. Sept 20, 1922 (Address) 801 N. 1st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVEMENT

DATE OF BURIAL

Holy RosarySept 21 1922

FUNERAL

ADDRESS

Wm G. Rydzewski 1648 Eastern

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67718

CERTIFICATE OF DEATH.

REGISTERED NO. C

PLACE OF DEATH

CITY OF BALTIMORE (No. St. Agnes Hospital)

ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

FULL NAME

Florence Young

(Residence in Baltimore: No. 2659 Lehman Street)

St.; yrs., 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Married
(Write the word.)

6-DATE OF BIRTH, July 28, 1866.
(Month) (Day) (Year)

7-AGE, 56 yrs. 1 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. House-work
(b) General nature of industry, business, or establishment in which employed (or employer). At home

9-BIRTHPLACE, (State or Country). Frederick Co. Md.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country). Not Known

12-MAIDEN NAME OF MOTHER Laura O. Reel

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin C. Young

(Address) 2659 Lehman St.

15- SEP 21 1922 ROBERT N. KRAUTER,

Filed. 191 Bureau Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 19 1922 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Investigation
(Inquest, au-

topsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis + Diabetes
following Automobile
Accident

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY Automobile Accident
(Secondary)

(Duration) yrs. mos. 8 ds.

(Signed) James M. Penlow M. D.
(Coroner.)

715 10., 1922 (Address) 705 E. Chase St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place Yonkers In the of death. yrs. mos. 8 ds. State. yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Frederick Ave. & Millington Ave.

Former or usual residence. 2659 Lehman St.

19-PLACE OF BURIAL OR REMOVAL,

Western Cemetery

20-UNDERTAKER

John F. Denny

DATE OF BURIAL

Sep't 22, 1922

ADDRESS

715 Light St

Volck.
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67719

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

ROBERT R. KRAUTER,

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

9/17

1922, to

9/20

1922

that I last saw her alive on

Sept 20

1922

and that death occurred, on the date stated above, at

7.30 A.M.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

(duration)

yrs.

mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67720

CERTIFICATE OF DEATH.

90 D 67720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Bolton ST., 15 WARD)

2-FULL NAME

Solomon Herman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2117 Bolton

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Pauline Herman

6 DATE OF BIRTH (month, day, and year) Aug 25, 1845

7 AGE Years 77 Months - Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 566

(b) General nature of industry, business, or establishment in which employed (or employer)

Travelling Salesman.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant Mr. Ernest Herman (Address) 2117 Bolton St.

15 Filed SEP 21 1922 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/20/22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 7, 19 22, to Sept 20, 19 22.

that I last saw him alive on Sept 20, 19 22.

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis Senilis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Edema of lung (Secondary) (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) Joseph E. Fisher, M. D.

, 19 (Address) 1576 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

Hebrew Friendship Cm 9/21/22

20 UNDERTAKER ADDRESS

David Sondheim 118 24th St
Royal Oak

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67721

CERTIFICATE OF DEATH.

31 D 67721

1-PLACE OF DEATH

City of BALTIMORE: (No. Cherry Hill, Westport, St., 25 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Frederick Erying,.....

(Residence in Baltimore: No. Cherry Hill, Westport, St.; yrs., 48 mos., ----- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, White, 5-Single, Married, Widowed, or Divorced, Single
(Write the word.)

6-DATE OF BIRTH, Do not know, 1.....
(Month) (Day) (Year)

7-AGE, 48 yrs., ----- mos., ----- ds. If LESS than 1 day, ----- hrs. or ----- min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) 046

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Robinson,

(Address) Westport.

15-SEP 21 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 19th, 1922, 192.....
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) ----- yrs., ----- mos., ----- ds.

CONTRIBUTORY (Secondary) -----

(Duration) ----- yrs., ----- mos., ----- ds.

(Signed) Edw. J. P. Smith M. D. (Coroner.)

Feb. 21st, 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, ----- yrs., ----- mos., ----- ds. In the State, ----- yrs., ----- mos., ----- ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mount Olivet Sept 22, 1922

20-UNDERTAKER, ADDRESS

John J. Fildes 1200 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Hls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67722

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 1 WARD)

2-FULL NAME

(a) RESIDENCE NO. 2232 Cambridge ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 40 mos. 40 ds. How long in U. S., if of foreign birth? 40 yrs. 40 mos. 40 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed,
or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Ida Hennish
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 14 1876

7 AGE Years 48 Months 1 Days 4 If LESS than
1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Laborer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

10 NAME OF FATHER Frank Hennish

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Sofia

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mrs Ida Hennish
(Address) 2232 Cambridge St

15 SEP 21 1922 ROBERT R. RAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from
Sept. 14, 1922, to Sept. 18, 1922,
that I last saw him alive on Sept 18, 1922,
and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:
Cancer of Prostate Metastatic
Cancer of glands of neck &
of liver

(duration) 4 yrs. 4 mos. 4 ds.

CONTRIBUTORY Cancer Jaundice
(Secondary)

(duration) 28 yrs. 28 mos. 28 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?
(Signed) D. J. Passano, M. D.

Sept. 18, 1922 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

St Stanislaus Sept 22 1922

20 UNDERTAKER

John Schneider 1803 Bank
St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67723

CERTIFICATE OF DEATH.

D 67723

1-PLACE OF DEATH

City of BALTIMORE: (No. *Edwin Murrey Corp* died on *10-10-1922* *5-10* *7* *area* *St.* *5-10* *Ward*)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Edmund P. Murrey

(Residence in Baltimore: No. *5-10* *7* *area*)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-Single, Married, Widowed, or Divorced. *Single* (Write the word.)

6-DATE OF BIRTH. (Month) (Day) (Year)

7-AGE. *68* *about* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Clerk* *off* (b) General nature of industry, business, or establishment in which employed (or employer). *Restaurant*

9-BIRTHPLACE. (State or Country). *Balto*

10-NAME OF FATHER. *Pat Murrey*

11-BIRTHPLACE OF FATHER. (State or Country). *Ireland*

12-MAIDEN NAME OF MOTHER. *Cath. Smith*

13-BIRTHPLACE OF MOTHER. (State or Country). *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). *Edmund Murrey*

(Address). *247 W. 10th St. B.C.*

15 SEP 21 1922

ROBERT A. KRAUTER,

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Sept. 19* 192*2* (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an. *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said. *inquest* and that said deceased came to. *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

suicide by pistol shot wound in abdomen
I believe this man has had
particulars for examination

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *W. H. Smith* M. D. (Coroner) *Sept 21* 192*2* (Address) *1639 Bury*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St Peter's Cemetery *Sept 22nd* 192*2*

20-UNDERTAKER. ADDRESS

George Schilling & Sons *1126 E Monument*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67724

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 15)

2-FULL NAME

(Residence in Baltimore: No. 3804)

WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word)

Single

6-DATE OF BIRTH,

Nov 13, 1916
(Month) (Day) (Year)

7-AGE,

5 yrs. 10 mos. 5 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None
odd

9-BIRTHPLACE,
(State or Country),

Petersburg, Va.

10-NAME OF FATHER,

John Paul George

11-BIRTHPLACE OF FATHER
(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Nell C. Jones

13-BIRTHPLACE OF MOTHER
(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John Paul George
3804 Bonner Road.

(Address)

15-

Filed

SEP 21 1922

191

ROBERT R. KRAUTER

JOHN P. G. G. G.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sep 18, 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
Sustained death
(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Automobile accident

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

Sept. 20, 1922 (Address) 7802 Eastman Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place In the
of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Grand Ridge, Md. Sept. 21, 1922

20-UNDERTAKER

ADDRESS

The Undertaker for North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Med. General Hospital* WARD)2-FULL NAME *Baby Watts. (2 not of Twins)*(a) RESIDENCE No. *3315 Powhatan Ave.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)*Female white**Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Sept 17, 1922*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*None*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore
Maryland*

10 NAME OF FATHER

Rowland Watts

11 BIRTHPLACE OF FATHER (city or town)

*Cecil Co.
Maryland*

(State or country)

12 MAIDEN NAME OF MOTHER

Norma Watts

13 BIRTHPLACE OF MOTHER (city or town)

*Baltimore
Maryland*

(State or country)

14

Informant

(Address)

*Mrs. Norma Watts
at home*

15

*SEP 21 1922*ROBERT R. WRAUTER
Registrar

BUTLER PRINTING CO.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 20 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Sept 19, 1922, to Sept 20, 1922.*that I last saw her alive on *Sept 20, 1922*and that death occurred, on the date stated above, at *10:25 A.M.*

The CAUSE OF DEATH* was as follows:

Congenital Stelectasia

(duration) yrs. mos. ds.

CONTRIBUTORY *Primature*
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *George E. Shannon* M. D., 19 (Address) *Med General Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

*Longwood Ave**Sept 21 1922*

20 UNDERTAKER

ADDRESS

W. H. Smith & Co. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.—PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67726

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital* ST. *10* WARD)

2-FULL NAME

Mrs Amelia Galster

(a) RESIDENCE. NO.

819 N Edgewood

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *45* yrs. mos.

ds. How long in U. S., if of foreign birth? *61* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Philip C. Galster

6 DATE OF BIRTH (month, day, and year) *Sept 18th 1858*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *64* *1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *not known* (State or country) *Germany*

10 NAME OF FATHER

Schlag

11 BIRTHPLACE OF FATHER (city or town) *not known* (State or country) *Germany*

12 MAIDEN NAME OF MOTHER

Gammell

13 BIRTHPLACE OF MOTHER (city or town) *not known* (State or country) *Germany*

14

Informant (Address)

Milton P. Galster
1034 Essex St

15

Filed

SEP 22 1922

ROBERT R. KRAUTER

Sanial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 19 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 18*, 1922, to *Sept 19*, 1922, that I last saw her alive on *Sept 19*, 1922, and that death occurred, on the date stated above, at *11.45 P. M.*

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Right sided paralysis

(duration) yrs. mos. *8 hrs*

CONTRIBUTORY *Generalized arteriosclerosis* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*

Was there an autopsy? *no*

What test confirmed diagnosis? *no*

(Signed) *Isidor J. Gray*, M. D.

, 19 (Address) *Hebrew Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Lauden Park Cem. *Sept 22 1922*

20 UNDERTAKER ADDRESS

Frank A. Tink *915 N. Gay St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67727

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 W. Lanvale ST. 11 WARD)

2-FULL NAME Walter Marion Powell

(a) RESIDENCE NO. 309 W. Lanvale

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 30th, 1863

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 58 8 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Gents Furnishings

(c) Name of employer Isaac Hamburger & Sons.

9 BIRTHPLACE (city or town) Baltimore Md, (State or country)

10 NAME OF FATHER Dr John F. Powell

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Alice Ann Tilyard 9.21.1922 (Address) 120 Airquith St.

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Harry F. Powell (Address) 309 W. Lanvale St.

15 Filed 21 1922 ROBERT R. MAUTER.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th, 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 22, 1922 to Sept. 20, 1922, that I last saw him alive on Sept. 20, 1922,

and that death occurred, on the date stated above, at 11-10 A m. The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert R. Mauter, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery

Sept-22 1922

20 UNDERTAKER

ADDRESS

Robert R. Mauter

1223 W. Lanvale St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-11—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 W. Montg., ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 116 W. Montgomery St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Cauc

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Married

6-DATE OF BIRTH,

5 years ago, 1 (Month) (Day) (Year)

7-AGE,

50

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Labourer

9-BIRTHPLACE, (State or Country),

Eng.

PARENTS.

10-NAME OF FATHER,

Joseph Fisher

11-BIRTHPLACE OF FATHER (State or Country),

Eng.

12-MAIDEN NAME OF MOTHER

Winfred

13-BIRTHPLACE OF MOTHER (State or Country),

Eng.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Wife

(Address).....

116 W. Montg.

15-

Filed

SEP 21 1922

191

ROBERT R. MAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 15 1922, to Sept 19 1922, that I saw him alive on Sept 14 1922, and that death occurred, on the date stated above, at 4:57 m. The CAUSE OF DEATH* was as follows:

Pressure on Robt

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....M. D. Sept 20, 1912 (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.....mos.....ds. In the Stateyrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Auburn

DATE OF BURIAL,

Sept 22, 1922

20-UNDERTAKER

R. Brown

ADDRESS

18 W. Montg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67730

HEALTH DEPARTMENT—CITY OF BALTIMORE

67730

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 Worsley St. WARD)

2-FULL NAME

Blue Leroy West

(a) RESIDENCE NO.

424 Worsley St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Feb yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) November 19, 1924

7 AGE Years 10 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Hermord West

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Hazel Tiler

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Hermord West (Address) 424 Worsley St

15 Filed SEP 21 1932 ROBERT A. KAUFER Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1932

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1932, to Sept 19, 1932, that I last saw him live on Sept 19, 1932,

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Intussusception

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) constipation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Geoff Hall, M. D.

, 19 (Address) 424 Worsley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Laurel Cemetery Sept 21, 1932

20 UNDERTAKER

ADDRESS 1725

Mrs Robert A Elliot Ashland

D 67731

HEALTH DEPARTMENT—CITY OF BALTIMORE

67731

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED No. C

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).

(Address).

15-

Filed SEP 21 1922

191

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

Sep. 20, 1922

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE-PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 67732

CERTIFICATE OF DEATH.

REGISTERED NO.

90 D 67732

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mount Hope Retreat* WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

68 yrs. 0 mos. 1 ds.

How long in U. S., if of foreign birth?

68 yrs. 0 mos. 1 ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Sept-19-1854

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

abt 68 0 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

William Leach

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Susanna Beaulieu

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Records of Mount Hope Retreat Mt Hope Md.

15

Filed SEP 21 1922

ROBERT A. MAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20th 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 20th 1909, to Sept 20, 1922, that I last saw her alive on Sept 20, 1922, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis -

abt

CONTRIBUTORY (Secondary) Maria Chronic (duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

20 1922 Address) Mount Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Green Mount Cemetery

20 UNDERTAKER

ART & MOWEN COMPANY

DATE OF BURIAL

Sept 21 1922

ADDRESS

108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Laticob ST., 12 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST., 1706 Laticob WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 9/17, 1922, to 9/19, 1922, that I last saw him alive on Sept. 18, 1922, and that death occurred, on the date stated above, at 10:45 P.M. The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

(Address) 1019 N. Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 21 1922

ROBERT A. KRAUTER

Bureau of Health

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67734

CERTIFICATE OF DEATH.

160 D 67734

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2552 N. Fayette St. WARD 70)

2-FULL NAME

(a) RESIDENCE. No. 2552 N. Fayette St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) June 13. 22
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
3 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant Leah's (Address) 2558 N. Fayette St.

15

Filed SEP 21 1922 ROBERT H. MAUTER Death Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1922, to Sept. 20, 1922, that I last saw her alive on Sept. 16, 1922, and that death occurred, on the date stated above, at 4 p. m. The CAUSE OF DEATH* was as follows:

As the cause of death was as follows:
Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. S. Warr M. D.

Address 801 V. E. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Western Cemetery Sept 21 1922
George L. Schwab 2401 E. 1st St.

D 67735

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2558 W. Balto. ST. 20 WARD)

2-FULL NAME

Elizabeth L. Winefield(a) RESIDENCE. NO. 2558 W. Balto. ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Wht. 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ludwig Winefield6 DATE OF BIRTH (month, day, and year) June 30 - 18497 AGE Years 83 Months 3 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Otto Schaub

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

PARENTS

14 Informant

Henry L. Winefield

(Address)

2017 W. Pratt St.

15

Informant

Robert H. Mauter

(Address)

2017 W. Pratt St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 3 1922, to Sept 20 1922,that I last saw her alive on Sept. 20 1922,and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard Kaler M. D., 19 (Address) 2027 Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Sept 22 1922

20 UNDERTAKER

George L. Schaub 2017 Pratt St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 21 1922

ROBERT H. MAUTER

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67736

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1903 Edmondson St., 16 WARD)

2-FULL NAME

Mary Susan Maslin

(a) RESIDENCE NO.

(Usual place of abode)

Rock-Hall, Md ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

8

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Thomas S. Maslin

6 DATE OF BIRTH (month, day, and year)

Sept 21 1869

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

about 55 years

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Rock-Hall Md.

10 NAME OF FATHER

Isaac Bryden

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Philadelphia Pa.

12 MAIDEN NAME OF MOTHER

Mary Crouch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Rock-Hall Md.

14

Informant

(Address)

Mrs Mary Esenwein
Route -2 Rock-Hall Md.

15

SEP 21 1922

ROBERT A. MAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 19th 1922 to Sept 21st 1922.

that I last saw him alive on Sept 20, 1922

and that death occurred, on the date stated above, at 2:40 a.m.

The CAUSE OF DEATH* was as follows:

diabetic necrosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. J. McElroy, M. D.

9/24/22 Address 408 N. Payson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Rock-Hall Maryland

DATE OF BURIAL

Sept 22 1922

20 UNDERTAKER

Joe J. Jendens & Son

ADDRESS

217 S. Race St.

MARGIN RESERVED FOR BUNDLING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Rhs.

(See Letter over)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67737

CERTIFICATE OF DEATH.

H 9 D 67737

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 N. Milton Ave. WARD)

2-FULL NAME

Anna Kucera

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

618 N. Milton Ave. ST.,

WARD

(Usual place of abode)
Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a ~~Married~~, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 12, 1866

7 AGE Years 56 Months 62 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) OOD
(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia
(State or country) Europe

10 NAME OF FATHER Dr. Stepanek

11 BIRTHPLACE OF FATHER (city or town) Bohemia
(State or country) Europe

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Bohemia
(State or country) Europe

14 Informant Anna Kucera
(Address) 618 N. Milton Ave.

15 SEP 21 1922 ROBERT R. KRAUTER,
Burial Permit 384

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/21/22 19

17
HEREBY CERTIFY, That I attended deceased from 9/21/22, 19, to 9/21/22, 19.
that I last saw her alive on 9/21/22, 19,
and that death occurred, on the date stated above, at 5:30 a.m.
The CAUSE OF DEATH* was as follows:

Cancer of Bladder

(duration) yrs. 9 mos. ds.
CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. 2 mos. 20 ds.

18 Where was disease contracted
if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?
(Signed) W. J. Sage M. D.
, 19 (Address) 709 N. B. Way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Holy Redeemer DATE OF BURIAL Sept 24, 22

20 UNDERTAKER Jirkler & Jirkler ADDRESS 739 Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67739

D 67739

1-PLACE OF DEATH

Bon Secours Hosp

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST. 14

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Eliz A. Reynolds

(Residence in Baltimore: No.

1731 Park Ave

St.; -- yrs., 6 mos. -- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

January

29

1854

(Month)

(Day)

(Year)

7-AGE,

6.7

yrs.

7

mos.

21

ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Baltimore, Maryland

PARENTS.

10-NAME OF FATHER,

V. Clinton Reynolds

11-BIRTHPLACE OF FATHER

(State or Country),

Buffalo, New York

12-MAIDEN NAME OF MOTHER

Rebecca Aitken

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore, Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clinton S. Reynolds

(Address) Parkton, Maryland

15-

Filed

Robert H. Hart

Registrar.

Burial Permit No. 7.4170

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September twentieth, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 20 1922, to Sept 20 1922,

that I saw her alive on Sept 20 1922,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Aortic aneurysm
dysphagia - starvation

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) Cathulaged M. D.

Sept 20, 1922 (Address) Bon Secours Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. 5 mos. 23 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1731 Park Ave, Balto Md

19-PLACE OF BURIAL OR REMOVAL,

Cathedral Cemetery

DATE OF BURIAL.

9/22, 1922

20-UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67740

D 67740

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Hannah Nelson*(a) RESIDENCE. NO. *Preston Valley No.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Calvert Co.*
(State or country) *Md.*

10 NAME OF FATHER

Leroy Nelson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

Pearce

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)*Sister Terrence*
Preston Valley

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 21 1922*

17

I HEREBY CERTIFY, That I attended deceased from

No record

19 to

19

that I last saw him alive on *Sept 18*, 1922.and that death occurred, on the date stated above, at *9 a. m.*

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. A. Warner

M. D.

21. 1922

(Address)

1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral**Sept 22 1922*

20 UNDERTAKER

ADDRESS

J. C. Wiedefeld 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P211922

D 67741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67741

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 Gorseuch Ave ST. 9 WARD)2-FULL NAME William T. Bayless(a) RESIDENCE NO. 712 Gorseuch Ave ST. 9 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5, 18637 AGE Years 59 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

Collector

(b) General nature of industry, business, or establishment in which employed (or employer).

for Gas Co

(c) Name of employer

9 BIRTHPLACE (city or town) Balt City (State or country)10 NAME OF FATHER John T Bayless11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt City12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mr. W. E. Welf (Address) 716 Gorseuch

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 192217 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Sept 19, 1922 that I last saw him live on Sept 19, 1922 and that death occurred, on the date stated above, at 4:25 P m. The CAUSE OF DEATH* was as follows:Chronic Arthritisfrom history (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Lushane, M. D.Address 3100 Harper Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

mt Olivet Cemetery Sept 22 1922

20 UNDERTAKER

ADDRESS

Chas. G. Black 7420 North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 21 1922

W.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67742 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67742

CERTIFICATE OF DEATH

1-PLACE OF DEATH
City of BALTIMORE: 20/8 Greenmount St. 12 Ward
2-FULL NAME Salvatore Rosso
(Residence in Baltimore: No. 20/8 Greenmount St.; yrs. 10 mos.ds.)

Registered No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, M. 4-COLOR OR RACE, White 5-STATUS, Married
6-DATE OF BIRTH, 8.15.1871
7-AGE, 57 yrs. 1 mos. 4 ds.
8-OCCUPATION: (a) Trade, profession, or kind of work, Shoemaker (b) General nature of industry, business, or establishment in which employed (or employer),
9-BIRTHPLACE, Italy
10-NAME OF FATHER, Philip Rosso
11-BIRTHPLACE OF FATHER, Italy
12-MAIDEN NAME OF MOTHER,
13-BIRTHPLACE OF MOTHER, Germania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph Rosso
(Address) 20/8 Greenmount St.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Sept 19 1922
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Coronary disease of heart
CONTRIBUTORY (Secondary)
(Signed) R. P. Harrison, M. D.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?

Former or usual residence.....
19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, 9/22/22
20-UNDERTAKER, George J. Pelt ADDRESS, 1735 Bayview Ave.

15- Robert P. Harrison, Registrar.
11522

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67743

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67743

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.)

2-FULL NAME

(Residence in Baltimore: No.)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER.
(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

Robert P. Harrison,

1922

1922

Registrar.

Burial Permit Clerk.

via American Railway Express

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

(Coroner)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, In the

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 67744

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 D 67744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *27 N Carey, Robt Garrett Hosp*
CITY OF BALTIMORE: (No. *27 N Carey* ST. *27* WARD)
2-FULL NAME *Charles Foss*
(a) RESIDENCE NO. *19 Spring Ave.* ST. *27* WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day, and year) *Feb. 1, 1922*
7 AGE Years *7* Months *14* Days *14* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant *Mrs Emma Foss*
(Address) *Spring Ave.*

15

Robert E. Harrison,
19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 21st 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Sept 14, 1922* to *Sept 21, 1922*
that I last saw him alive on *Sept 21st, 1922*
and that death occurred, on the date stated above, at *11:45 A. m.*
The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. *10* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. W. Clift* M. D.
9/24, 1922 (Address) *27 N. Carey St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Robert Brooks & Son

DATE OF BURIAL

9/23rd 1922

ADDRESS

CP2 11922

Serial Forfeit Claim

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67745

31 D 67745

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Veterans' Hosp. #56, ST. 17 WARD)
Baltimore, Md.

2. FULL NAME Lewis Bradford

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 920 Pear St.,
(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1893

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
29 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Singer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) --
(State or country)

12 MAIDEN NAME OF MOTHER --

13 BIRTHPLACE OF MOTHER (city or town) --
(State or country)

14 Informant Hospital Record
(Address) Ft. McHenry, Md.

15 SEP 22 1922 ROBERT R. MAUTER,
Filed Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 1922

17 I HEREBY CERTIFY, That I attended deceased from
August 5, 1922 to Sept. 19, 1922.

that I last saw him alive on September 19, 1922

and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis chronic pulmonary

-- (duration) -- yrs. -- mos. -- ds.

CONTRIBUTORY
(Secondary)

(duration) -- yrs. -- mos. -- ds.

18 Where was disease contracted
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Record

(Signed) W. Barker, Surgeon R. D.

9-19-22 U.S. Veterans' Hosp. #56.
Address W. P. Dwyer

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67746

CERTIFICATE OF DEATH.

168D 67746

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1108 Riggs Ave. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1108 Riggs Ave. St. 38 yrs. 38 mos. 38 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. Colored 5-Single, Married, Widowed, or Divorced. Married (Write the word.)

6-DATE OF BIRTH. April 1884 (Month) (Day) (Year)

7-AGE. 38 yrs. 38 mos. 38 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housewife (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Md.

10-NAME OF FATHER. Ed. West

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Dora's Kump

13-BIRTHPLACE OF MOTHER. (State or Country). Dora's Kump

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Allan N. Brown

(Address) 1108 Riggs Ave.

15. Filled SEP 22 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.)

find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Signed) J. T. Hennessey, M. D. (Coroner.)

Sept. 21, 1922. (Address) 2802 E. Lombard Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St. Auburn Cem. Sept 23, 1922

20-UNDERTAKER. ADDRESS 378

Sam'l M. Mowley

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1009 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67747

CERTIFICATE OF DEATH.

D 67747

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 318-N. 28 ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 318-N. 28 ST. 12 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Bl

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr. 6, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Mr. P. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Lucy H. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mr. P. Clark
318-N. 28

15

Filed SEP 22 1922

ROBERT A. KNAUTH,
Registrar

Local Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 20 1922

17

HEREBY CERTIFY, That deceased from

Sept 18, 1922, to Sept 20, 1922

that I last saw him alive on Sept 20, 1922

and that death occurred on the date stated above, at 9 A m.

The CAUSE OF DEATH was as follows:

Influenza

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P. Clark, M. D.

19 (Address) 1034 - Trust Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cemetery Sept 21 1922

20 UNDERTAKER

Samuel H. Hensley

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *524 W Conway* ST.: *22* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *524 W. Conway* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. *30* mos. *30* ds.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female White**Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

*John C. Holman*6 DATE OF BIRTH (month, day, and year) *1873*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *California*

10 NAME OF FATHER

David Gitchell

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Caroline Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

*John C. Holman**524 W Conway St*

15

File

ROBERT B. MAUTER,

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 20 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1922, to Sept 20, 1922,
that I last saw him alive on *Sept 20, 1922,*and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Chr. Intestinal Nephritis

CONTRIBUTORY (Secondary)

(duration) *3* yrs. *0* mos. *0* ds.(duration) *2* yrs. *2* mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral Cem**Sept 23 1922*

20 UNDERTAKER

F. A. France & Son

ADDRESS

739 Hammer

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67749 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH. 707D 67749
1-PLACE OF DEATH
City of BALTIMORE: (No. 4444 Redwood St. 26 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME John Martin
(Residence in Baltimore: No. 19 Anthony Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.		
3-SEX <u>Male</u>	4-COLOR OR RACE <u>White</u>	5-Single, Married, Widowed, or Divorced. <u>Married</u> (Write the word.)	16-DATE OF DEATH. <u>Sept 20</u> 19 <u>22</u> (Month) (Day) (Year)		
6-DATE OF BIRTH (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <u>inquest</u> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <u>inquest</u> (Inquest, autopsy or inquiry.) that said deceased came to <u>his</u> death on the day stated above.		
7-AGE <u>55</u> yrs. <u>8</u> mos. <u>8</u> ds. If LESS than 1 day, hrs. or min.?			The CAUSE OF DEATH* was as follows: <u>Fract. Skull</u> <u>Building fell on him</u> <u>at about 10:30 p.m.</u>		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).			CONTRIBUTORY (Secondary) <u>inquest will be held</u> <u>Tonight</u> (Duration) yrs. mos. ds. (Signed) <u>W. J. Riley</u> M. D. <u>Sept 21</u> 19 <u>22</u> (Address) <u>1139 E. Bay</u>		
9-BIRTHPLACE. (State or Country). <u>Balto</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
PARENTS	10-NAME OF FATHER. <u>John E. Martin</u>		18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Board Residents). At place of death <u>Sept</u> yrs. mos. ds. In the State yrs. mos. ds.		
	11-BIRTHPLACE OF FATHER. <u>Balto</u>		Where was disease contracted, if not at place of death?		
	12-MATERN NAME OF MOTHER. <u>Emma Wilson</u>		Former or usual residence		
	13-BIRTHPLACE OF MOTHER. <u>Balto</u>		19-PLACE OF BURIAL OR REMOVAL. <u>London Park Cem.</u> DATE OF BURIAL. <u>Sept 23/22</u>		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>Fannie Martin</u> (Address) <u>19 Anthony Ave</u> <u>Washington</u>			20-UNDERTAKER. <u>F. A. 71 same & Son</u> ADDRESS <u>739 Howard</u>		
15- Filed <u>SEP 22 1922</u> ROBERT A. MAUTER <u>Burial Permit</u> Registrar.					

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No hemorrhage.
Due to old
age.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67750

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67750

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1900 W Pratt ST. 19 WARD)

2. FULL NAME

(a) RESIDENCE NO. 1900 W Pratt ST. 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

SEP 22 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 19 1922, to Sept 20 1922, that I last saw him alive on Sept 20 1922, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy) (duration) yrs. mos. 12 hrs

CONTRIBUTORY (Secondary)

Arterio-sclerosis Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. S. Fink, M. D. (Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral

20 UNDERTAKER MRS. N. S. FINK,

FUNERAL DIRECTORS

1838 W. Pratt Street

DATE OF BURIAL

Sept 23 1922

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67751 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 780 Bradley St. 17 Ward)

2-FULL NAME Francis Barney
(Residence in Baltimore: No. 780 Bradley St. I. 6 yrs., 18 mos., 18 ds.)

Registered No. 10
(If death taken in hospital or institution give the NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX <u>Female</u>	4-COLOR OR RACE <u>colored</u>	5-Single, Married, Widowed, or Divorced. <u>Single</u> (Write the word.)	16-DATE OF DEATH <u>Sept. 20</u> , 192 <u>2</u> (Month) (Day) (Year)	
6-DATE OF BIRTH <u>March 2</u> , 192 <u>2</u> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held un- (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above. The CAUSE OF DEATH* was as follows: <u>Gastro-Enteritis</u>	
7-AGE <u>6</u> yrs., <u>18</u> mos., <u>18</u> ds. If LESS than 1 day, hrs. or min.?			CONTRIBUTORY (Secondary) <u>no history</u>	
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
9-BIRTHPLACE (State or Country) <u>Balto. Md.</u>			18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death... yrs... mos... ds. State... yrs... mos... ds. Where was disease contracted, if not at place of death?	
PARENTS.	10-NAME OF FATHER <u>Perry Barney</u>		19-PLACE OF BURIAL OR REMOVAL <u>909 Calver Ave</u>	
	11-BIRTHPLACE OF FATHER (State or Country) <u>Md.</u>		DATE OF BURIAL <u>Sept 22</u>	
	12-MAIDEN NAME OF MOTHER <u>Eliza Crosby</u>		20-UNDERTAKER <u>Daniel Egan</u>	
	13-BIRTHPLACE OF MOTHER (State or Country) <u>Md.</u>		ADDRESS <u>Ba</u>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>Perry Barney</u> (Address) <u>780 Bradley St.</u>				
15-SEP 22 1922 Filed ROBERT R. KRAUTER Burial Permit Clerk				

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

D 67752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E Balto ST., 6 WARD)

2-FULL NAME Samuel Isaac Levin

(a) RESIDENCE No. 1036 E. Lombard ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred

_____ yrs.

_____ mos.

_____ ds.

How long in U. S., if of foreign birth? 28 yrs. _____ mos. _____ ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 67752

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 62 Months _____ Days _____ If LESS than 1 day, _____ hrs. or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Russia (State or country) _____

10 NAME OF FATHER Meyer Levin

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country) _____

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country) _____

14 Informant G. Levin (Address) 1036 E Lombard St

15 Filed SEP 22 1922 19 _____ ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 21 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sep. 20, 19 22, to Sep. 21, 19 22.

that I last saw him alive on Sep. 21, 19 22.

and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

General paralysis

(duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY to dilatation of heart (Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) W. B. Bayler M. D.

9/22, 1922 (Address) 210 N. 1st St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Col

20 UNDERTAKER Mat Levinson

DATE OF BURIAL

Sept 21 19 22

ADDRESS 1127

E. Balto St

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67753

D 67753

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1911 Harlem Ave* ST.; *16* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1911 Harlem Ave* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OF RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married* (Write the word.)6-DATE OF BIRTH, *June 22, 1873* (Month) (Day) (Year)7-AGE, *49* yrs. *2* mos. *30* ds. If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *037*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Balto. Md.*10-NAME OF FATHER, *William T. Henry*11-BIRTHPLACE OF FATHER (State or Country), *Balto. Md.*12-MAIDEN NAME OF MOTHER *Maggie E. Martin*13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Mrs. Bessie Braun*(Address), *1911 Harlem Ave*

15-

Filed SEP 22 1922

ROBERT R. KRAUTER,
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 21, 1922* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 10 1922*, to *Sept. 21 1922*, that I saw her alive on *Sept. 20 1922*, and that death occurred, on the date stated above, at *1 a. m.* The CAUSE OF DEATH* was as follows:*Acute arthritis*(Duration) yrs. *2* mos. *11* ds.
CONTRIBUTORY (Secondary) *Endocarditis*(Duration) yrs. mos. *7* ds.
(Signed) *Wm. C. Todd* M. D.
Sept 21 1922 (Address) *735 N. Fulton*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *London Park Cem* DATE OF BURIAL, *Sept. 25 1922*20-UNDERTAKER, *W. J. McKee Sons* ADDRESS *North Pa*

THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67754

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 731 Reservoir ST., 13 WARD)

2-FULL NAME

Charles W. Ryan

(a) RESIDENCE No. 731 Reservoir

(Usual place of abode)

ST., _____ WARD _____

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Emma R. Ryan

6 DATE OF BIRTH (month, day, and year) Oct 6, 1868

7 AGE Years 63 Months 11 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Tele

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Sarah Parrott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Emma R. Ryan (Address) 731 Reservoir St.

15 Filed SEP 22 1932 ROBERT A. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1921, to Sept 20 1922

that I last saw him alive on Sept 14 1922 and that death occurred, on the date stated above, at 7:35 m.

The CAUSE OF DEATH* was as follows:

Coronary artery thrombosis and heart failure

CONTRIBUTORY (Secondary) hypertension (duration) 1 yrs. — mos. — ds.

(duration) 1 yrs. 1 mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? X-ray examination (Signed) W. H. M. Hays, M. D.

, 19 22 (Address) 204-L P. St. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Sept 22 1922

20 UNDERTAKER John O'Connell ADDRESS 1201 W. Fayette St.

WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001
D 67755

D 67755

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital*)

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Boy Barber

(a) RESIDENCE. No.

University Hosp. ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 19/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

1 day

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

University Hosp. Balt. Md.

10 NAME OF FATHER

George C. Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Carroll Co. Md.

12 MAIDEN NAME OF MOTHER

Ellen M. Lipsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Carroll Co. Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

SEP 22 1922

ROBERT A. KRAUTER

Barth Parrott Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 19 1922, to *Sept. 20 1922*.

that I last saw him alive on *Sept. 20 1922*.

and that death occurred, on the date stated above, at *10.30 a.m.*

The CAUSE OF DEATH* was as follows:

Chromaturia

(duration)

Yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Nephritic Toxemia

(duration)

Yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

O. P. Baugh M. D.

, 19 (Address)

University Hosp.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

ADDRESS

SEP 22 1922

WITH UNFADING INK—THIS IS A PERMANENT RECORD
Physicians should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very
important. See instructions on back of certificate.

D 67756

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

St.: 11 WARD)

2-FULL NAME

(Residence in Baltimore: No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

(Month)

(Day)

(Year)

7-AGE,

52

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filled

191

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ascertained by Illness - Gas
1 yr. 11 mos. 10 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D. (Coroner.)

Sept. 21, 1912 (Address) 1077 Bay

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

67757

CERTIFICATE OF DEATH.

REGISTERED NO. 199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Betty Michaels*(a) RESIDENCE. NO. *813 W. North Ave.* ST. WARD.(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *18* yrs. *—* mos. *—* ds. How long in U. S., if of foreign birth? *18* yrs. *—* mos. *—* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years *21* Months *—* Days *—* If LESS than 1 day, hrs. *—* or min. *—*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*10 NAME OF FATHER *Abraham Penn*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*12 MAIDEN NAME OF MOTHER *Hannie Hertz*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*14 Informant (Address) *A. Penn 813 W. North Ave.*15 *SEP 22 1922* *ROBERT R. KRAUTER* Registrar
Burial Permit Clerk. *H.A.M.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 22 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept. 17 1922*, to *Sept. 22 1922*, that I last saw her alive on *Sept. 22 1922*, and that death occurred, on the date stated above, at *7.30 a.m.*
The CAUSE OF DEATH* was as follows:*Abortion, Incomplete (Self-Induced)*

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? *813 W. North Ave.*Did an operation precede death? *Yes* Date of *Sept. 17, 1922*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *W. Backe* M. D.(Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Southern Ave Sept 22 1922

20 UNDERTAKER

ADDRESS *1127 E. Balto St**A. G. G. & Co.*

UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be in plain terms, so that it may be properly classified. See instructions on back of certificates.

THIS UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information fully supplied. AGE should be stated EXACTLY. PHYSICIANS should state H in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67758 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67758

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Spruce ST. 2 WARD)

2-FULL NAME

John Alfred Smith

(a) RESIDENCE NO. 2008 Spruce ST. 2 WARD 2

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 1922

7 AGE Years 6 Months 20 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Martin Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Stanislaw Bilsha

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Martin Smith (Address) 2008 Spruce St

15 SEP 22 1922 Registrar J. H. M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 12 1922 to Sept 21 1922 that I last saw him alive on Sept 21 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY Tubercular Meningitis (Secondary)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. H. Keller, M. D.

(Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Rosary Sep 23 1922

20 UNDERTAKER John W. Weber 1803 Bank

THIS IS A PERMANENT RECORD
be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
in terms, so that it may be properly classified. Exact statement of OCCUPATION is very
important on back of certificate.

D 67760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2600 Roslyn Ave.

ST. 15 WARD)

REGISTERED NO. C

(If death occurred in a
hospital or institution,
give its NAME instead
of street and number and
fill out No. 18.)

2-FULL NAME William Robert Bartgis

(Residence in Baltimore: No. 2600 Roslyn Ave.

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, November 19th, 1869 (Month) (Day) (Year)

7-AGE, 52 yrs. 10 mos. 1 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, President Bartgis Printing Co. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Frederick, Md.

10-NAME OF FATHER, George W. Bartgis

11-BIRTHPLACE OF FATHER (State or Country), Frederick, Md.

12-MAIDEN NAME OF MOTHER Sophia E. Ortner

13-BIRTHPLACE OF MOTHER (State or Country), Frederick, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Allen Bartgis

(Address) 2600 Roslyn, Md.

15-ROBERT R. KRAUTER, Registrar, Filed 22 1922

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, September 20th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) J. D. Hennessy, M. D. (Coroner.) Sept. 20, 1922 (Address) 2802 Edmondson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery DATE OF BURIAL, Sept. 22, 1922

20-UNDERTAKER, Joseph B. Cook ADDRESS, 1003 N. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D 67761
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 N. Fremont ST., 18 WARD)

2-FULL NAME

Luigia Albi

(a) RESIDENCE No.

126 N. Fremont

ST., 18 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 8-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

9

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto City Md.

10 NAME OF FATHER

Camillo Albi

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Angelina Amato

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Camillo Albi
126 N. Fremont

15

File

SEP 22 1922

ROBERT R. KAUTER,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1922, to Dec 21, 1922.

that I last saw her alive on Dec 20, 1922.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Primary

Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi S. Stefano M. D.
Sept 21, 1922 (Address) 407 N. Eads St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Catholic Cemetery

Sept 22, 1922

20 UNDERTAKER

ADDRESS

George F. Ruth 1735 Harford

D 67762

HEALTH DEPARTMENT—CITY OF BALTIMORE

1001
D 67762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 N. Gilmore ST.; 16 WARD)

2-FULL NAME

Howard Smith Brown Jr.(Residence in Baltimore: No. 1222 N. Gilmore

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 9 yrs., 2 mos., 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)Single

6-DATE OF BIRTH,

Dec 19th, 1921
(Month) (Day) (Year)

7-AGE,

9 yrs., 2 mos., 21 ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)Child9-BIRTHPLACE,
(State or Country),Balto, Md.

PARENTS.

10-NAME OF FATHER,

Howard S. Brown11-BIRTHPLACE OF FATHER
(State or Country),Md

12-MAIDEN NAME OF MOTHER

Eva Fraction13-BIRTHPLACE OF MOTHER
(State or Country),Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Howard S. Brown

(Address)

1222 N. Gilmore St.

15-

Robert P. Harrison

191

Registrar.

Burial Permit 01621

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 22nd, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 20 1922, to Sept 22nd 1922,
that I saw him alive on Sept 21st 1922,and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(Duration) 2 yrs., 2 mos., 21 ds.CONTRIBUTORY
(Secondary)Acute Bronchitis(Duration) 7 yrs., 2 mos., 21 ds.(Signed) Harry S. Brown M. D.Sept 22nd 1922 (Address) 1501 Reservoir

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 9 yrs., 2 mos., 21 ds. In the State 9 yrs., 2 mos., 21 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL

McAuleySept 24th, 1922

20-UNDERTAKER

ADDRESS

Carmel Smith1364 MaryTHIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S. S. Love ST.; 1 WARD)2-FULL NAME Carl F. W. Brandt(Residence in Baltimore: No. 812 S. S. Love St.; 29 yrs., — mos., — ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Mar 11, 1860
(Month) (Day) (Year)

7-AGE,

62 yrs., 6 mos., 9 ds.

If LESS than 1 day,

....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Laborer
in general

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Ida Brandt

(Address)

812 S. S. Love St.

15-

Robert P. Harrison,

Filed

191

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 20, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 15 1922, Sept 20 1922that I saw him alive on Sept 19 1922and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
Nephritis(Duration) 1 yrs., — mos., — ds.

CONTRIBUTORY (Secondary)

Chronic Myocarditis(Duration) 6 yrs., — mos., — ds.(Signed) Harold B. Titlow M. D.9/21, 1922 Address 315 S. Highland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Lawn

DATE OF BURIAL,

Sept 23, 1922

20-UNDERTAKER

Peter Nicolaus

ADDRESS

2060 Eastern

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAINTAIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67764

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D 67764

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 E. Church ST., 22 WARD)

2-FULL NAME

Anna S. Robbio

(a) RESIDENCE No.

228 E. Church

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 16 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

4

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Harry Robbio

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Bessie Redele

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant

(Address)

Harry Robbio
228 E. Church

15

Robert P. Hartman

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/21 - 1922

17

I HEREBY CERTIFY, that I attended deceased from Sept 17, 1922, to Sept 21, 1922, that I last saw him alive on Sept 21, 1922, and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Enterocolitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 10 ds.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. H. M. D.

, 19 (Address) 9/22/22

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

St. Peter's Cemetery
F. A. Frame & Son

DATE OF BURIAL

ADDRESS

Sept 22/22
703 Hager

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67766

CERTIFICATE OF DEATH.

45 D 67766

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 Beaumont Ave 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Hammond Bowerman(Residence in Baltimore: No. 526 Beaumont Ave

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-STATUS,
MARRIED, Married
WIDOWED
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov 7, 1856
(Month) (Day) (Year)

7-AGE,

65 yrs. 10 mos. 13 ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, Salesman(b) General nature of industry, business, or establishment in which employed (or employer), Wholesale Millinery9-BIRTHPLACE,
(State or Country), Id10-NAME OF FATHER, Gen. Richard H. Bowerman11-BIRTHPLACE OF FATHER
(State or Country), Id12-MAIDEN NAME OF MOTHER Eliza Hammond13-BIRTHPLACE OF MOTHER
(State or Country), Id

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella S. Bowerman(Address) 526 Beaumont Ave

15-

Filed 1922Robert P. Harrison,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 20, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 8 1922, to Sept 20 1922,that I saw him alive on Sept 20 1922,and that death occurred, on the date stated above, at 7²⁰ m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

..... (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary) Exhaustion

..... (Duration) yrs. mos. ds.

(Signed) E. H. Duncan M. D.Sept 21, 1922 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Green Mount Cemetery, 1922

20-UNDERTAKER

ADDRESS

John Ollitchell 1201 W. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67767

CERTIFICATE OF DEATH.

148 D 67767

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5 ST., 5 WARD)2-FULL NAME Mary Forti(a) RESIDENCE NO. 441 N. Front St. ST., 5 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

(or) WIFE of

Alfonzo Forti

6 DATE OF BIRTH (month, day, and year)

19077 AGE Years 18 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy10 NAME OF FATHER Domenik Petrelli

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy12 MAIDEN NAME OF MOTHER Albina Deagnella

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy14 Informant (Address) JOHNS HOPKINS HOSPITAL15 Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21st 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1922, to Sept 21st, 1922, that I last saw him alive on Sept 21/22, 1922.and that death occurred, on the date stated above, at 11:02 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pregnancy & Pyelitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

W. W. Gray

M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Washington D C

DATE OF BURIAL

9/23rd 1922

20 UNDERTAKER

Robert Brooks & Son

ADDRESS

Calhoun & Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 22 1922

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67768

D 67768

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1239 W. Cross ST., WARD)

2. FULL NAME Conrad Doerr Sr

(a) RESIDENCE NO. 1239 W. Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

60 yrs.

2 mos.

ds.

How long in U. S., if of foreign birth?

60

yrs.

2

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male white Widowed

5a If married, widowed, or divorced HUSBAND of Catherine Doerr (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19 1888

7 AGE Years 84 Months 5 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Doerr

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant George Doerr (Address) 1239 W. Cross ST.

15 1922 1022 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1922

I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to Sept 21, 1922, that I last saw him live on Sept 21, 1922, and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Semblity (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. S. M. D.

(Address) 1176 W. Cross ST.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

20 UNDERTAKER

for founders Son

DATE OF BURIAL

Sept 25 1922

ADDRESS

2178 Bay

HEALTH DEPARTMENT—CITY OF BALTIMORE

67769

CERTIFICATE OF DEATH.

X 1730 67768

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., WARD)

2-FULL NAME

James Dial

(a) RESIDENCE NO.

Pembroke, R.D. - S.E. ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown

ds. — How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of

Fannie Dial (wife)

6 DATE OF BIRTH (month, day, and year)

Sept. 12, 1877

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

45

1

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

S.E.

10 NAME OF FATHER

Marcus Dial

11 BIRTHPLACE OF FATHER (city or town) (State or country)

S.E.

12 MAIDEN NAME OF MOTHER

Elizabeth Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

S.E.

PARENTS

14 Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Robert P. Harrison

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 21, 1922, to Sept 22, 1922.

that I last saw him alive on Sept 22, 1922,

and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Operation for gall stones

(duration) yrs. mos. ds.

21 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9/27/22

Was there an autopsy? yes

What test confirmed diagnosis? urine blood, physical

(Signed) Agnes Blalock, M. D.

1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Pembroke N.E.

UNDER-TAKER

Joseph Wren

DATE OF BURIAL

Sept 26 2

ADDRESS

221 Bury

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

22 1922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67771

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D 67771

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph's Hosp 24* St. *24* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *1143 Hull St* St.; yrs. *16* mos.ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-MARITAL STATUS

Married
(Write the word.)

6-DATE OF BIRTH

July 25 1883
(Month) (Day) (Year)

7-AGE

39 yrs. *8* mos. *26* ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Stenographer
Foreman

9-BIRTHPLACE,
(State or Country),

Germany

PARENTS.

10-NAME OF FATHER,

Martin Schwann

11-BIRTHPLACE OF FATHER,
(State or Country),

Germany

12-MAIDEN NAME OF MOTHER,

undknown

13-BIRTHPLACE OF MOTHER,
(State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

1922

Robert F. Harrison

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 20 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquest find that said deceased came to *death*
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage - Pro-
truded Skull - Full strength & healthy
on St. Castle Bridge

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. S. Pater* M. D.

(Coroner.)

9-22-1922 (Address) *508 E. Mt. Vernon*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Schwartz Cemetery

Sept 23, 1922

20-UNDERTAKER

ADDRESS

John Reelick

1508 Calver

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67772

CERTIFICATE OF DEATH.

113 D 67772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 Maryland Ave ST., 25 WARD)

2-FULL NAME

Marie C Watkins

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

305 Maryland Ave ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 28 - 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1—25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Leon Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Louise Hays

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Leon Watkins
305 Maryland Ave

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22/1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1922 to Sept 22, 1922,that I last saw him alive on Sept 22, 1922,and that death occurred, on the date stated above, at 74 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Myrtle A. Davis, M.D.

19

(Address)

1000 Calverton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park CemeterySept 25 1922

20 UNDERTAKER

ADDRESS

Geo Leimbach & Son 647 N. Pratt

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67773

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 12

ST.

WARD)

2. FULL NAME

Byrd Thomas Owens.

(a) RESIDENCE NO.

2204 Hunter St. City

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single

5a If married, widowed, or divorced

Husband of

or wife of

Emma T. Byrd Owens (parent)

6 DATE OF BIRTH (month, day, and year)

Dec. 10, 1921.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town; State or country)

Balto. Md.

10 NAME OF FATHER

Byrd Owens.

11 BIRTHPLACE OF FATHER (city or town; State or country)

U. S.

12 MAIDEN NAME OF MOTHER

Emma Carpenter.

13 BIRTHPLACE OF MOTHER (city or town; State or country)

Virginia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 21 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 5, 1922, to Sept 21, 1922.

that I last saw him alive on Sept 21, 1922.

and that death occurred, on the date stated above, at 1:40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray + Tbcn. test

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

mt auburn

Sept 23 1922

20 UNDERTAKER

ADDRESS

Joseph A. Farrell

2319 Division

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

SEP 23 1922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

67774 HEALTH DEPARTMENT—CITY OF BALTIMORE 67774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 815 Park. Av. St. 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Ella Smith
(Residence in Baltimore: No. 815 Park. Av. St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.		
3-SEX <u>Female</u>	4-COLOR OR RACE <u>Col.</u>	5-Single, Married, Widowed, or Divorced. <u>Div</u> (Write the word.)
6-DATE OF BIRTH <u>Aug 3</u> 18 <u>82</u> (Month) (Day) (Year)		
7-AGE <u>60</u> yrs. <u>1</u> mos. <u>17</u> ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>Waitress</u> (b) General nature of industry, business, or establishment in which employed (or employer). <u>086</u>		
9-BIRTHPLACE (State or Country). <u>Va.</u>		
PARENTS	10-NAME OF FATHER.	<u>Beckman</u>
	11-BIRTHPLACE OF FATHER. (State or Country).	<u>Unknown</u>
	12-MAIDEN NAME OF MOTHER.	<u>Beckman</u>
	13-BIRTHPLACE OF MOTHER. (State or Country).	<u>Unknown</u>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dad Lee Butler
(Address) 2233 Laurel Hill Ave

15-
Robert J. Harrison.
Registrar.

CORONER'S CERTIFICATE OF DEATH.	
16-DATE OF DEATH. <u>Sept 20</u> 19 <u>32</u> (Month) (Day) (Year)	
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, and that said deceased came to his death topsy or inquiry on the day stated above. The CAUSE OF DEATH* was as follows: <u>Valv. dis. heart</u> <u>Swain</u> (Duration) yrs. mos. ds. CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) <u>W. H. Biddle</u> M. D. (Coroner.) <u>1639 2nd</u> 192 <u>2</u> . (Address)	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds. Where was disease contracted, if not at place of death?	
Former or usual residence	
19-PLACE OF BURIAL OR REMOVAL. <u>St. Zim. Cem.</u>	DATE OF BURIAL. <u>Sept 22</u> 19 <u>32</u>
20-INTERTAKER. <u>Sam'l. H. ...</u>	ADDRESS <u>578</u>

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67775

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 Biddle St. W. ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Ashton(Residence in Baltimore: No. 440 W Biddle St.; 15 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Blk 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Widow
(Write the word.)6-DATE OF BIRTH, May —, 1868.
(Month) (Day) (Year)7-AGE, 54 yrs., 4 mos., — ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer). 9-BIRTHPLACE, (State or Country), Martinsburg W. Va10-NAME OF FATHER, Thos Taylor11-BIRTHPLACE OF FATHER (State or Country), Martinsburg W. Va12-MAIDEN NAME OF MOTHER unknown13-BIRTHPLACE OF MOTHER (State or Country), Martinsburg

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benzon M. Mappin(Address) 440 W Biddle

15-

Filed Sept 23 1922 HARRISON

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9th 21, 1922.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 15 1922, to Sept 21 1922, that I saw her alive on Sept 20th 1922, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
supervening on Myocardial Insufficiency
(Duration) 2 yrs., 6 mos., 6 ds.CONTRIBUTORY masarica
(Secondary)(Duration) yrs., 6 mos., 6 ds.(Signed) Eustas Goldman M. D.9/21/22 (Address) 656 W Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.Where was disease contracted, if not at place of death? Former or usual residence 19-PLACE OF BURIAL OR REMOVAL, Not BuriedDATE OF BURIAL, Sept 22nd, 192220-UNDERTAKER Samuel ThompsonADDRESS 578 W Biddle St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67776

CERTIFICATE OF DEATH

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital
CITY OF BALTIMORE: (No. Eastern Ave. ST. 6 WARD)

2-FULL NAME George Smallwood

(a) RESIDENCE NO. 304 N. Valley ST. WARD (Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Smallwood

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE Years 45 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Co. Va (State or country)

10 NAME OF FATHER John Smallwood

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Hospital Records (Address)

15 Registrar Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-21 1922

17 I HEREBY CERTIFY, That I attended deceased from 8-12, 1922, to 9-21, 1922, that I last saw him alive on 9-21, 1922, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Carcinoma of stomach with metastasis to liver + lymph glands (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 1922

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy (Signed) Richardson Jones, M. D.

9-21, 1922 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Astory Cemetery DATE OF BURIAL Sept 24, 1922

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725 Oakland St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Ashland Ave. ST., 10 WARD)

2-FULL NAME

Catherine Kretz

(a) RESIDENCE NO. 1207 Ashland Ave. ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? Sept yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26 1850

7 AGE Years 72 Months 5 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) ood
(c) Name of employer

9 BIRTHPLACE (city or town) Balt. (State or country) Md.

10 NAME OF FATHER John Kretz

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Franciska Betz

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mrs. Annie E. Kretz (Address) 1207 Ashland Ave.

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1922, to Sept 22 1922.

that I last saw him alive on Sept 22 and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed H. A. Warner, M. D. 23, 1922 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer Cemetery DATE OF BURIAL Sept 26 1922

20 UNDERTAKER Henry Horgensen ADDRESS 1301 E. Egan

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *912 S Clinton* ST. *46* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John Jenkins*(Residence in Baltimore: No. *912 S. Clinton* St. *50* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *M*4-COLOR OR RACE. *N*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH, *March 5, 1862*

(Month)

(Day)

(Year)

7-AGE, *60* yrs. *6* mos. ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Engineer*
(b) General nature of industry, business, or establishment in which employed (or employer) *130*9-BIRTHPLACE, (State or Country), *Males*10-NAME OF FATHER, *Thomas Jenkins*11-BIRTHPLACE OF FATHER (State or Country), *Males*12-MAIDEN NAME OF MOTHER *Mary Harris*13-BIRTHPLACE OF MOTHER (State or Country), *Males*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Alveta Jenkins*(Address) *912 S. Clinton St.*

15-

Filed *Robert P. Harrison,*

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sep 20, 1912*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from *July 5, 1912* to *Sep 20, 1912*, that I saw him alive on *Sep 20, 1912*, and that death occurred, on the date stated above, at *8:30 a.m.*

The CAUSE OF DEATH* was as follows:

Adenocarcinoma of stomach & rectum(Duration) *1* yrs. mos. ds.CONTRIBUTORY (Secondary) *Swanston*(Duration) *4* yrs. mos. ds.(Signed) *Edward C. T. Rogers, M. D.**Sep 21, 1912* (Address) *1322 Parkman*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery*DATE OF BURIAL, *Sep 23, 1912*20-UNDERTAKER *Jinkler + Jinkler*ADDRESS *1739 E. Eager*THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

23 1912

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67779

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67779

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 2 Cleveland ST., 21 WARD)

2-FULL NAME

Mary E. Graves

(a) RESIDENCE NO.

116 2 Cleveland ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yr.

mos.

ds.

How long in U. S., if of foreign birth?

yr.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/22/1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1921 to Sept 22, 1922, that I last saw her alive on Sept 22, 1922, and that death occurred, on the date stated above, at 2:50 p m. The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Bowels
(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X-Ray & Autopsy
(Signed) Stephen A. Harrison, M. D.
, 19 (Address) 1227 Columbia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Lauson Park
George J. Smith

Sept 25 1922
1000
H. Foyette

D 67780

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 W. Lexington ST.: 20 WARD)

2-FULL NAME

John L. Knight

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1922 W. Lexington ST. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Marie B. Knight

6 DATE OF BIRTH (month, day, and year)

June 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry L. Knight

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaret R. Roche

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant

(Address)

Charles O. Knight

1914 W. Lexington St.

15

EP 231922

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 2nd, 1922, Sept 22nd, 1922

that I last saw him alive on Sept 22nd, 1922

and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

Tuberculosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Dr. D. McCleary, M. D.

(Address)

400 N. Payson St.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Garden Park

Sept 25 1922

20 UNDERTAKER

ADDRESS

George J. Smith

H. Fagot

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67781

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *22* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Joseph J. Jurek*

(Residence in Baltimore: No. *25 W. Camden St.* St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. *Married*
(Write the word.)

6-DATE OF BIRTH *Don't Know*
(Month) (Day) (Year)

7-AGE *60* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). *Russian*

10-NAME OF FATHER. *Don't Know*

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER. *2 2 2*

13-BIRTHPLACE OF MOTHER, (State or Country). *2 2*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. J. Jurek*

(Address) *40 Parkers St.*

15- *Robert J. Harrison*

16- *31922* Burial Permit *1922* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 18* 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said... and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(Duration) *4 1/2 hours* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Don't Know*
(Duration) yrs. mos. ds.

(Signed) *W. H. G. M. D.* (Coroner.)
9-23-1922 (Address) *117 W. Camden St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

St Stanislaus Sept 19 1922

20-UNDERTAKER, ADDRESS

John G. Harrison 412 W. Camden St.

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every person of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67782

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 17 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-23 1922

17

I HEREBY CERTIFY That I attended deceased from

9-17-22 to 9-23 1922

that I last saw him alive on 9-23-1922

and that death occurred, on the date stated above, at 4:35 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) G. F. Hoff M. D.

19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

SEP 23 1922

Printed Name of Registrar

Geo. W. Hoff & Son

2503 E. Madison Ave

D 67783

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67783

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3244 Abell Ave ST., 12 WARD)

2-FULL NAME

Mary C. Smith

(a) RESIDENCE NO.

3244 Abell Ave ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

Widowed
(or) WIFE of William Smith6 DATE OF BIRTH (month, day, and year) Aug 6, 1850

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.72116

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(h) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

W. Va.

10 NAME OF FATHER

William J. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not Ascertained

12 MAIDEN NAME OF MOTHER

Mary C. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not Ascertained

14

Informant
(Address)Marie A. Smith
3244 Abell Ave

15

Robert F. Harrison

19

Registrar

Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 8, 1921, to Sept 22, 1922that I last saw him live on 18, 1922and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH was as follows:

Chronic Endocarditis
(Mitral Incompetency)At Home (duration) 1 yrs. 6 mos. — ds.CONTRIBUTORY
(Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Ruppard M. D.(Address) 3100 Abell Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Em

DATE OF BURIAL

Sept 25, 1922

20 UNDERTAKER

William Cook

ADDRESS

502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P23 1922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67784

HEALTH DEPARTMENT—CITY OF BALTIMORE

3
D 67784

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Franklin St. No. 19* Ward)

Registered No. C.....

2-FULL NAME

Percy Grammer

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *54 Vincent* St./yrs., mos., ds.)

St./yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Colored* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH, *Sept 17*, 19*07* (Month) (Day) (Year)

7-AGE, *15* yrs., *2* mos., *2* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). *None*

9-BIRTHPLACE, (State or Country), *Va*

10-NAME OF FATHER, *John Grammer*

11-BIRTHPLACE OF FATHER, (State or Country), *Va*

12-MAIDEN NAME OF MOTHER, *Effie Thomas*

13-BIRTHPLACE OF MOTHER, (State or Country), *Va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Effie Grammer*

(Address) *54 Vincent St.*

15-

Filed *Robert P. Harrison* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 19*, 19*22* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Autopsy* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Autopsy* and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

*Fracture Ribs, lacerated
A large, unhealed
hemorrhage, and as a result
one hour ds.*

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) *James M. D.* (Coroner.)

Sept 23, 19*22*. (Address) *100 E. Charles*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, *Franklin St. 19* In the *one* *hr* of death, yrs., mos., ds. State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Rayette & Mowbray

Former or usual residence, *54 Vincent St.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Petersburg Va *Sept 24*, 19*22*

20-UNDERTAKER, ADDRESS *114 W.*

Branson & Leland Schodack

Spec. 6-9-19—H. P. Co.—1000 Bks.
D 67785
HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.
1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Univ. Hospital 11 ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2-FULL NAME Lois Duers
(a) RESIDENCE No. 1314 Mc Culloh ST. WARD. (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
PERSONAL AND STATISTICAL PARTICULARS
3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) infant
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day, and year) July 1922
7 AGE Years 3 Months Days If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town). Maryland (State or country)
PARENTS
10 NAME OF FATHER Ed Duers
11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)
12 MAIDEN NAME OF MOTHER Lee Watford 9/22, 1922 Address Univ. Hospital
13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)
14 Informant Hospital records (Address)
15 SEP 23 1922 Registrar
MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) Sept 21 1922
17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 19 22, to Sept. 21, 19 22, that I last saw her alive on Sept. 21, 19 22, and that death occurred, on the date stated above, at 9:30 A. M.
The CAUSE OF DEATH* was as follows:
chronic enterocolitis
(duration) unknown ds.
CONTRIBUTORY Marasmus (malnutrition) (Secondary) (duration) not known ds.
18 Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy history lab. findings
(Signed) M. D.
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)
19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL Sept 23 1922
20 UNDERTAKER John H. Toading ADDRESS 142 W. 1st St.

Spec. 6-9-19—H. P. Co.—1000 Bks.
D 67785
HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.
1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Univ. Hospital 11 ST.: WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2-FULL NAME Lois Duers
(a) RESIDENCE No. 1314 Mc Culloh ST. WARD. (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
PERSONAL AND STATISTICAL PARTICULARS
3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced (write the word) infant
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day, and year) July 1922
7 AGE Years 3 Months Days If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town). Maryland (State or country)
PARENTS
10 NAME OF FATHER Ed Duers
11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)
12 MAIDEN NAME OF MOTHER Lee Watford 9/22, 1922 Address Univ. Hospital
13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)
14 Informant Hospital records (Address)
15 SEP 23 1922 Registrar
MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) Sept 21 1922
17 I HEREBY CERTIFY, That I attended deceased from Sept. 18, 19 22, to Sept. 21, 19 22, that I last saw her alive on Sept. 21, 19 22, and that death occurred, on the date stated above, at 9:30 A. M.
The CAUSE OF DEATH* was as follows:
chronic enterocolitis
(duration) unknown ds.
CONTRIBUTORY Marasmus (malnutrition) (Secondary) (duration) not known ds.
18 Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of
Was there an autopsy? yes
What test confirmed diagnosis? autopsy history lab. findings
(Signed) M. D.
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)
19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL Sept 23 1922
20 UNDERTAKER John H. Toading ADDRESS 142 W. 1st St.

THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 620 Archer ST. 2 WARD)

2-FULL NAME

George W. Johnson

(a) RESIDENCE NO. 620 Archer

ST. 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Eleanor Johnson

6 DATE OF BIRTH (month, day, and year) June - 1882

7 AGE Years 70 Months 3 Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

Janitor

(c) Name of employer

Baug & Chem. Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Elyia

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Annie Arnold
Maryland

14

Informant
(Address)

Eleanor Johnson
620 Archer St

15

Filed

SEP 23 1922

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 21 1922

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1922 to Sept 21, 1922, that I last saw him alive on Sept 20, 1922, and that death occurred, on the date stated above, at 1:05 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of
(Gastric)

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

myocarditis + arterio
sclerosis (duration) 3 mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) David J. Sanchez M. D.

9/21, 1922 Address 122 W. See St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Auburn

Sept 23, 22

20 UNDERTAKER

ADDRESS 142

John H. Joadin usiel St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67787

D 67787

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3901 Orleans St

ST. 10 WARD

2-FULL NAME

ANNA HEDLE.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

* (a) RESIDENCE. No.

3901 Orleans St

ST. 10 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

X yrs.

X mos.

X

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

No

6 DATE OF BIRTH (month, day, and year)

Sept. 19, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

X

X

X

X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

No

(b) General nature of industry, business, or establishment in which employed (or employer)

No

(c) Name of employer

No

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.
3901 ORLEANS ST

10 NAME OF FATHER

LEO HEDLE.

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

MARGARET LAMPKUHLE.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant (Address)

MARGARET LAMPKUHLE.
3901 Orleans St.

15

Filed

19

Robert E. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 19, 1922, to Sept 19, 1922

that I last saw her alive on Sept 19, 1922

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

15 min

CONTRIBUTORY (Secondary)

Congenital Malformation

Heart

(duration) X yrs. X mos. 30 min

18 Where was disease contracted

if not at place of death?

Same

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Same

(Signed) Jas. L. O'Meara, M. D.

Address 248 E 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

J.H.U.

SEP 23 1922

Baltimore, Md.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67788

HEALTH DEPARTMENT—CITY OF BALTIMORE

199 D 67788

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Pronounced dead at*
City of BALTIMORE: (No. *Franklin General Hospital* St. *19* Ward)
2-FULL NAME *James Walker*
(Residence in Baltimore: No. *1605 W Franklin* St.; yrs. *5* mos. *14* ds.)

Registered No. C.....
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.		
3-SEX. <i>Male</i>	4-COLOR OR RACE. <i>Colored</i>	5-Single, Married, Widowed, or Divorced. <i>Single</i>
6-DATE OF BIRTH. <i>Jan 22 1898</i> (Month) (Day) (Year)		
7-AGE. <i>24 yrs. 8 mos. 27 ds.</i>		If LESS than 1 day. hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Schaeffer</i> (b) General nature of industry, business, or establishment in which employed (or employer). <i>Private family</i>		
9-BIRTHPLACE. (State or Country). <i>Balt. City</i>		
PARENTS.	10-NAME OF FATHER. <i>Daniel Walker</i>	
	11-BIRTHPLACE OF FATHER. (State or Country). <i>Maryland</i>	
	12-MAIDEN NAME OF MOTHER. <i>Lizzie Harris</i>	
	13-BIRTHPLACE OF MOTHER. (State or Country). <i>Maryland</i>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Lizzie Carrington</i> (Address) <i>1605 W Franklin</i>		

15-
Filed *31922* *Robert P. Harrison,* Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.	
16-DATE OF DEATH. <i>Sept 20 1922</i> (Month) (Day) (Year)	
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>Autopsy</i> (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said <i>Autopsy</i> find that said deceased came to <i>his</i> death (Inquest, autopsy or inquiry.) on the day stated above. The CAUSE OF DEATH* was as follows: <i>Bullet wound through the heart (Murder)</i> (Duration) <i>5</i> yrs. <i>10</i> mos. <i>14</i> ds. CONTRIBUTORY (Secondary) (Duration) <i>5</i> yrs. <i>10</i> mos. <i>14</i> ds. (Signed) <i>James M. Kenton</i> M. D. (Coroner.) <i>Sept 22 1922</i> (Address) <i>700 E Chase St</i> State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. 18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence. 19-PLACE OF BURIAL OR REMOVAL. <i>MD Jon City</i> DATE OF BURIAL. <i>9-24-22</i> 20-UNDERTAKER. <i>George H. Holland</i> ADDRESS <i>1631 Krumpholtz</i>	

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67798

CERTIFICATE OF DEATH.

D 67789

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S. Fremont ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dorothy Ruth Lamson

(a) RESIDENCE NO.

330 S. Fremont St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 3 mos. 4 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 18-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Melvin Lamson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Clara Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Canton

14

Informant

(Address)

Wm. H. Hark

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 22nd 22

17

I HEREBY CERTIFY, That I attended deceased from Aug 8th 1922, to Sept 22nd 1922, that I last saw her alive on Sept 20th 1922, and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Exhaustion

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

9/22/22 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm. G. Tice (net & Jans)

CHAS. A. ADE

1. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P23 1922

Burial Permit 61234

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Phy. rather indignant about Census Bureau's inquiries. Could give no cause for the malnutrition. No further history.

Spec.—1-10-21—M&T—1500 Rka.

Spec.—1-10-21—M&T—1500 Rka.

D 67790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2804 Hardford Ave 9 WARD)

2-FULL NAME

Florida Hall

(a) RESIDENCE NO.

2804 Hardford Ave

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs.

How long in U. S., if of foreign birth?

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

A. J. Hall

6 DATE OF BIRTH (month, day, and year)

Feb 7 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

7

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

W. B. Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Mary A Hall 2804 Hardford Ave

15

Filed

Robert P. Harrison

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 20, 1920, to Sept 22, 1922

that I last saw him alive on Sept 2, 1922

and that death occurred, on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Cancer Rt Breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of Oct 14, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. J. Zimmerman M. D.

9/23, 1922 (Address) 9865 Humphreys Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Northwood Cemetery Sept 25 1922

20 UNDERTAKER

ADDRESS

W. J. Tucker & Son Northwood

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67791

67791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3160 Leeds ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. Lohman(a) RESIDENCE. NO. 3160 Leeds ST. 20 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasoid 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMary Lohman

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 73 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Howard Co10 NAME OF FATHER William Lohman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa12 MAIDEN NAME OF MOTHER Mary C. Lohman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Northern

14

Informant (Address)

Mrs. J. Lohman

15

Filed Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 19 22

17 I HEREBY CERTIFY, That I attended deceased from

Aug 10, 19 22, to Sept 20, 19 22that I last saw him alive on Sept 20, 19 22,and that death occurred, on the date stated above, at 50 m.

The CAUSE OF DEATH was as follows:

Arterial Sclerosis
Cerebral Hemorrhage
Paralysis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W. Jones, M. D.(Address) 2111

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Star CemeterySept 21 19 22

20 UNDERTAKER

ADDRESS

Edward W. Pize903 EdmondandCalonsville

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

EP231922 Burial Permit Clerk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

67792

HEALTH DEPARTMENT—CITY OF BALTIMORE

67792

67792

CERTIFICATE OF DEATH.

41

67792

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 N. Gay

ST. 10

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 715 N. Gay

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

5 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Vogt.

6 DATE OF BIRTH (month, day, and year) Dec 22 1830

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

9

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. Maryland

(State or country)

10 NAME OF FATHER Philip Muehling

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER Margaret Rau

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

19

ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 21 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 18, 1922, to Sept 21, 1922

that I last saw him alive on Sept 21, 1922

and that death occurred, on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Insect bite on arm

(duration) yrs. mos. 5 ds.

18 Where was disease contracted At her home

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John J. Patach M. D.

9/21, 1922 (Address) 936 E. Monument St.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Michael Cemetery Balto. Co. Sept 24 1922

20 UNDERTAKER

ADDRESS

Fred Lussan Sons Pullerton

11- Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

67793

HEALTH DEPARTMENT—CITY OF BALTIMORE

67793

D 67793

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C. 67793...

City of BALTIMORE: (No. *Johns Hopkins Hospital* St. *177* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... *Mary Francis Mautens*

(Residence in Baltimore: No. *Cortice* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *Black* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH, *Apr* 1922 (Month) (Day) (Year)

7-AGE, *1* yrs. *4* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *Child* (b) General nature of industry, business, or establishment in which employed (or employer) *god*

9-BIRTHPLACE, (State or Country), *Cortice Md*

10-NAME OF FATHER, *George Mautens*

11-BIRTHPLACE OF FATHER, (State or Country), *Md*

12-MAIDEN NAME OF MOTHER, *Betha*

13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Chateau*

(Address) *Phoenix Md*

15- SEP 24 1922 ROBERT R. KRAUTER, Filed 1922 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept* 22 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows: *Accidental - Swallowed Concentrated Lye*

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *J. H. Pater* M. D. (Coroner.) *9-23-22* (Address) *505 E. N. W. Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Hereford Md* DATE OF BURIAL, *9/24* 1922

20-UNDERTAKER, *Sam'l Wendup* ADDRESS, *578 W. Bick*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 5th Carrollton Ave St. 18 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1710 W Lexington St.; yrs. mos. ds.)

St. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

colored

5-Single, Married, Widowed, or Divorced. (Write the word.)

Single

6-DATE OF BIRTH,

Jan. 12 1972
(Month) (Day) (Year)

7-AGE,

50 yrs. mos. ds.

If LESS than 1 day,

... hrs. or ... min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

004
Barber

9-BIRTHPLACE,

(State or Country),

Ind.

PARENTS.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER, (State or Country),

unknown

12-MAIDEN NAME OF MOTHER,

unknown

13-BIRTHPLACE OF MOTHER, (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Bertha Prescott

(Address),

7 Belair Ind.

15-

Filed

SEP 24 1922

ROBERT R. KRAUTER

Death Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 18 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, au-

topsy or inquiry.) find that said deceased came to this death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

suicide
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Penland M. D.
(Coroner.)

July 23 1922 (Address) 700 E Ches St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Belair Ind.

Sept. 24 1922

20-UNDERTAKER,

ADDRESS

Thurs. G. Locks

1302 Jefferson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67795

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 Bennett Place ST.; 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Annie Green(Residence in Baltimore: No. 907 Bennett Place St.; 36-yrs.,mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

7

4-COLOR OR RACE,

W5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH

Sept 28/64 1
(Month) (Day) (Year)

7-AGE,

57 yrs. 11 mos. 29 ds. If LESS than 1 day,hrs. or.....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany10-NAME OF FATHER, John J. Mohr11-BIRTHPLACE OF FATHER (State or Country), Germany12-MAIDEN NAME OF MOTHER, Margaret Green13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Family M. Green(Address) 907 Bennett

15-

SEP 24 1922 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 23rd 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1st 1922 to Sept 23rd 1922
that I saw her alive on Sept 22/22 1922,
and that death occurred, on the date stated above, at 2 m.

The CAUSE OF DEATH* was as follows:

Secondary anemia

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Endocarditis of long standing (Duration) yrs. mos. ds.(Signed) H. F. Hill M. D......, 191... (Address) 1208 Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Lorain Cem - DATE OF BURIAL, Sept 25 1922

20-UNDERTAKER

Geo H Little ADDRESS 2700 Edmonson

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67796

CERTIFICATE OF DEATH.

D 67796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ Hospital ST.: 1 WARD)

2-FULL NAME

Anita Cascia

(a) RESIDENCE. NO.

446 S. Robinson ST.

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred

yrs.

9

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Chas. Cascia

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Rose Marten

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Chas. Cascia
446 S. Robinson

15

FILED

SEP 24 1922

ROBERT R. KRAUTER,

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 2319 22

17

I HEREBY CERTIFY, That I attended deceased from August 30, 19 22, to Sept 23, 19 22.that I last saw him alive on Sept 23, 19 22, and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Enteric intoxicationNot known

(duration)

yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Not known

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical History

(Signed)

G. C. Hatten

M. D.

19 PLACE OF BURIAL

CREMATION OR REMOVAL

DATE OF BURIAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL

CREMATION OR REMOVAL

DATE OF BURIAL

19 PLACE OF BURIAL

CREMATION OR REMOVAL

DATE OF BURIAL

19 PLACE OF BURIAL

CREMATION OR REMOVAL

DATE OF BURIAL

19 PLACE OF BURIAL

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19 PLACE OF BURIAL

CREMATION OR REMOVAL

DATE OF BURIAL

19 PLACE OF BURIAL

CREMATION OR REMOVAL

DATE OF BURIAL

19 PLACE OF BURIAL

CREMATION OR REMOVAL

DATE OF BURIAL

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67797

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 Forest.

ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Cefali

(Residence in Baltimore: No. 415 Forest

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F 4-COLOR OR RACE, W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S

6-DATE OF BIRTH, 9-1-1922
(Month) (Day) (Year)

7-AGE, 23 yrs., mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), 415 Forest St.

10-NAME OF FATHER, Frank Cefali

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Angeline Mazioli

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Cefali(Address) 415 Forest St.

15-SEP 24 1922
Filed.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 9-24-1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 9-22-1922, to 9-24-1922 that I saw her alive on 9-22-1922, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastric Intestinal Infection
(Duration)..... yrs..... mos..... ds.

CONTRIBUTING CAUSE (Secondary).....
(Duration)..... yrs..... mos..... ds.

(Signed) S. J. Duman M. D.
9-24-1922 (Address) 1604 E. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. VincentDATE OF BURIAL, 9/24/2220-UNDERTAKER, Geo. J. PuthADDRESS, 1735 ...

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67798

D 57798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6000 Bellona Ave ST.; 4 WARD)

REGISTERED NO. C

2-FULL NAME Leonard McPhail Nelson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 409 W. Saratoga St.; 68 yrs., 9 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed6-DATE OF BIRTH, Dec - 10 - 1853
(Month) (Day) (Year)7-AGE, 68 yrs., 9 mos., 12 ds. 12 LESS than 1 day, ... hrs. or ... min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) O/S9-BIRTHPLACE, (State or Country), Baltimore Md.10-NAME OF FATHER, Thomas J. Nelson11-BIRTHPLACE OF FATHER (State or Country), Md12-MAIDEN NAME OF MOTHER Emily L. McPhail13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie A. Lousant(Address) 411 Hawthorne Road15- SEP 24 1922 ROBERT H. MAUTER

Filed..... 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept. 22, 1922
(Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from Sept. 17, 1922 to Sept. 22, 1922, that I saw him alive on Sept. 22, 1922, and that death occurred, on the date stated above, at 5 m.The CAUSE OF DEATH* was as follows:
Pulmonary Edema. Enlarged Prostate.
Urinary obstruction, some kidney involvement...... (Duration) yrs. mos. ds.
CONTRIBUTORY Chronic Pulmonary
(Secondary) Infection
..... (Duration) yrs. mos. ds.
(Signed) M. Gibson M. D.
9/23, 1922 (Address) 422 Retford Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Landon Park DATE OF BURIAL, Sept. 25, 192220-UNDERTAKER John Outtichell ADDRESS 12011 N. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67799

CERTIFICATE OF DEATH.

D 67799

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST.: _____ WARD)

2-FULL NAME

(a) RESIDENCE. No. _____ ST.: _____ WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

SEP 24 1922

ROBERT A. KAUFER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 22, 1922, to Sept 23, 1922, that I last saw her alive on Sept 23, 1922, and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria, laryngeal

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

9/24/22

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67800

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1504 Harlem ST., WARD 16

2-FULL NAME

Bennet Ball Lynch

(a) RESIDENCE No. 1504 Harlem ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen M. Lynch

6 DATE OF BIRTH (month, day, and year) Aug 17 1845

7 AGE Years 77 Months 1 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Maulin's

(c) Name of employer

Agust

9 BIRTHPLACE (city or town) (State or country)

Phila

10 NAME OF FATHER

James Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Phila

12 MAIDEN NAME OF MOTHER

Finette Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Phila

14

Informant (Address)

Helen M. Lynch 1504 Harlem

15

Filed

SEP 24 1922 ROBERT R. MAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922 to Sept 22, 1922, that I last saw him alive on Sept 22, 1922, and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy (Signed) John A. Gians, M. D.

19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Mount

20 UNDERLIER

John A. Gians

DATE OF BURIAL

Sept 25 1922

ADDRESS

North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

Filed

JOHNS HOPKINS HOSPITAL.

ROBERT R. MAUTER

Registrar

JOHNS HOPKINS HOSPITAL ST. 18 WARD

MARYLAND

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 19, 1922, to Sept 22, 1922.

that I last saw her alive on Sept 22, 1922, at 145 P. M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Brain tumor, right frontal

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home, Baltimore

Did an operation precede death? Yes, Date of Sept. 22

Was there an autopsy? Yes, antisept. head

What test confirmed diagnosis? X-ray, and air duplex

(Signed) F. H. Reichert M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Woodlawn Cem. North Pa

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION. AGE should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67802

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 23 WARD)

2-FULL NAME

(a) RESIDENCE. No.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

SEP 24 1922

ROBERT R. KRAUTER Registrar

Burial Permit Cloth.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 11 1922 to Sept 23 1922 that I last saw him alive on Sept 22 1922

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Congenital weakness, premature birth - (8 mos gest) difficult feeding

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. D.

9/23, 1922 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill

9-24 1922

20 UNDERTAKER

ADDRESS

E. H. Hark 115 E West St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67803

CERTIFICATE OF DEATH.

D 67803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3023 Belmont Ave ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 3023 Belmont Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. - mos. - ds. How long in U. S., if of foreign birth? 67 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9 1854

7 AGE Years 67 Months 6 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

SEP 24 1922

ROBERT A. KAUFER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1922, to Sept 22, 1922, that I last saw her alive on Sept 21, 1922, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis -
Chronic interstitial nephritis
Myocarditis - paralysis

(duration) yrs. 9 mos. 22 ds.

CONTRIBUTORY

(Secondary) of heart

(duration) yrs. 10 mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed)

Walter S. Riblett, M. D.

19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery Sept 25 1922

20 UNDERTAKER

ADDRESS

Chas. & Black 742 W. North Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67804

067804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST.: 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME

Abraham Smith

(a) RESIDENCE. NO.

(Usual place of abode)

ST. Pera WARD. Indiana

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Steward

(b) General nature of industry, business, or establishment in which employed (or employer)

Railroad

(c) Name of employer

B & O railroad

9 BIRTHPLACE (city or town) (State or country)

Indiana

10 NAME OF FATHER

Wm Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Indiana

12 MAIDEN NAME OF MOTHER

Mary Rumor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Indiana

14

Informant (Address)

Hospital Records

15

Filed

SEP 25 1922

ROBERT H. KRAUTER Registrar

Curial Parent Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 23 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept. 11, 19 22, to Sept 23, 19 22, that I last saw him alive on Sept 23, 19 22, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease (aortic regurgitation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Anthony V. Buchner, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Pera Indiana

Sept 28 19 22

20 UNDERTAKER

ADDRESS

Harry H. Witzke

11314 Lombard

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

67805
D 67805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67805

D 67805

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *7* WARD)

2-FULL NAME

Mr. George Caskie

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. *3700 Houston Ave.*

ST.

WARD

Houston, Texas

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. *3*

mos. *13*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Mr. George Caskie

6 DATE OF BIRTH (month, day, and year) *Apr. 17 1891*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

41

5

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Bridge man 073

(b) General nature of industry, business, or establishment in which employed (or employer)

SP. Railroad

(c) Name of employer

SP. Railroad

9 BIRTHPLACE (city or town) (State or country)

Texas

10 NAME OF FATHER *John Caskie*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Mary*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant (Address)

Johns Hopkins Hospital

15

Filed

SEP 25 1922

ROBERT A. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 28 1922*

17

I HEREBY CERTIFY, That I attended deceased from

July 21 1922 to Sept 22 1922

that I last saw him alive on *Sept 22 1922*

and that death occurred, on the date stated above, at *9:30 P. M.*

The CAUSE OF DEATH* was as follows: 1

Gradual respiratory failure following operation for removal of cysts from Cerebellum

(duration) yrs. *9* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Texas*

Did an operation precede death? *Yes* Date of *May 31 - June 13 1922*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Examination of cysts*

(Signed) *Ira H. Allen*, M. D.

, 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

HOUSTON, TEXAS

DATE OF BURIAL

9/28/22

20 UNDERTAKER

H.E. HUGHES

ADDRESS

424 N. BROADWAY

Spec. - 1-10-21-M&T-1500 Bks.

67806
D 67806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Sq. Hospital* ST. *16* WARD) -

2-FULL NAME *Mr August Williams*

(a) RESIDENCE NO. *803 Woodland* ST. _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred *7* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Eda Williams*

6 DATE OF BIRTH (month, day, and year) *Nov. 5-1868*

7 AGE Years Months Days If LESS than 1 day, _____ hrs. or _____ min.
53 10 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Labourer*

(b) General nature of industry, business, or establishment in which employed (or employer) *Iron Foundry*

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) *Conn.*

PARENTS

10 NAME OF FATHER *Jonas Williams*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Amisa*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *Mrs Ida Williams*
(Address) *803 Woodland St*

15 Filed *SEP 26 1922* *ROBERT R. KRAUTER* Registrar

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 24 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Aug 19*, 1922, to *Sept 24*, 1922, that I last saw him alive on *Sept 23*, 1922, and that death occurred, on the date stated above, at *7:25 A m.*

The CAUSE OF DEATH* was as follows:
Suppurative appendicitis

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) *Generalized peritonitis*
(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? *Baltimore Md.*

Did an operation precede death? *yes*, Date of *Aug 19, 1922*

Was there an autopsy? *no*

What test confirmed diagnosis? *Operative findings*
(Signed) *R D Harman*, M. D.
, 19 (Address) *Franklin Sq. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT *Anna pch's bnd* DATE OF BURIAL *Sept 25 1922*

20 UNDERTAKER *George R. Schwal* ADDRESS *111 Buck Ave*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bk.

67807
D 67807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67807
48 D 67807

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

610W. Lexington ST. 4

WARD)

2-FULL NAME

John Barranco.

(a) RESIDENCE No.

610W Lexington ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

44 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

44 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Catherine Barranco

6 DATE OF BIRTH (month, day, and year)

April 9-1858

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

64

5

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fruit Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Italy

10 NAME OF FATHER

Salvatore Barranco

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Rose Gardina

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Catherine Barranco 610W Lexington

15

Filed

19

SEP 25 1922 ROBERT R. REGISTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1922

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1922, to Sept. 23, 1922,

that I last saw him alive on Sept 22, 1922,

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rt. Side of Face.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myer A. Weinberg, M. D.

, 19 (Address) 1724 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cemetery

UNDERTAKER

H M Rouison

DATE OF BURIAL

Sept 25 1922

ADDRESS

239 N. Green St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

67808
D 67808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

67808
D 67808

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2724 N Charles ST. 27 WARD)

2. FULL NAME OF DECEASED: Phillip D Anglen Sibley

(a) RESIDENCE NO. 3309 St George Ave ST. WARD

(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Sept. 13 1916

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 6 yrs. — 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Newton C. Sibley

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Elsie B. Lemmon

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Phillip M. Lemmon (Address) 3309 St. George Ave.

15 Filed SEP 25 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1922 to Sept 23, 1922 that I last saw him alive on Sept 23, 1922 and that death occurred, on the date stated above, at 12:30 P.M. The CAUSE OF DEATH* was as follows: Vaccination

(duration) yrs. mos. 28 ds. CONTRIBUTORY (Secondary) Tetanus (duration) yrs. mos. 2

18 Where was disease contracted if not at place of death? 3309 St. George Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pharyngitis

(Signed) Dr. J. F. H. M. D.

9/23/1922 (Address) 2724 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Woodlawn Cemetery

20 UNDERTAKER

W M Routon

DATE OF BURIAL

Sept 26 1922

ADDRESS

223 F W

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67809

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Leadenhall ST., 22 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed SEP 25 1922

ROBERT A. KAUFER Registrar

Burial Permit 614

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 20th 1922, to Sept 23rd 1922, that I last saw him alive on Sept 23rd 1922,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. 4 mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 2

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. H. Carroll M. D.

19124 (Address) 140 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mr. Auburn

Sept 25 1922

20 UNDERTAKER

ADDRESS

John H. Toadwin

140 W. Hill St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67810

D 67810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 S Bond

ST., 3 WARD)

2-FULL NAME GERTRUD E. HUTCHISON

(a) RESIDENCE No. 103 S Bond

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

FEMALE

4 COLOR OR RACE

WHITE

5 Single, Married, Widowed, or Divorced, (write the word)
SINGLE

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

APRIL 26 1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

4

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Jack Hutchison

11 BIRTHPLACE OF FATHER (city or town)

Balto

(State or country)

MD.

12 MAIDEN NAME OF MOTHER Christyna Koscielski

13 BIRTHPLACE OF MOTHER (city or town)

Balto

(State or country)

MD

14

Informant Alice Koscielski
(Address) 226 S Ann St.

15

Filed

SEP 25 1922

ROBERT A. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/23 1922

17

I HEREBY CERTIFY, That I attended deceased from

9/17, 1922, to 9/23, 1922.

that I last saw him alive on 9/23, 1922.

and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

9 years of arteriosclerosis & thrombosis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sygne & S. S. S.

(Signed)

1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Rosary

Sep 25 1922

20 UNDERTAKER

ADDRESS

JOHN M. WEBER

1803 BANK ST.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67811

CERTIFICATE OF DEATH.

113 D 67811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 617 S PATTERSON PK. ave ST. 1 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME STEPHEN . BIELIK

(a) RESIDENCE No. 617 S PATTERSON PK. ave ST. _____ WARD _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR OR RACE WHITE 5 Single, Married, Widowed, or Divorced, (write the word) SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Dec 26 1921

7 AGE Years Months Days If LESS than 1 day, hrs or min. 8 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) ood
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Wladyslaus. Bielik

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Maryanna. Sobol

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Mrs Maryanna. Bielik (Address) 617 S Patterson Pk. Ave

15 Filed SEP 25 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) SEP 24 1922

17 I HEREBY CERTIFY, That I attended deceased from 9/22, 1922, to 9/24, 1922, that I last saw him alive on 9/22, 1922, and that death occurred, on the date stated above, at 11:30 A. m. The CAUSE OF DEATH* was as follows:

gastroenteritis & shock
colitis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) heart failure & indigestion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? sugar & albumin
(Signed) H. A. Dittberg M. D.

7/24/1922 (Address) 1627 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Rosary Sep 25 1922

20 UNDERTAKER JOHN M. WEBER 1803 BANK ST ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

67812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. C

67812

1 PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs. mos. ds.)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

7-AGE

If LESS than
1 day, hrs.
or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(h) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE
(State or country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

191

ROBERT H. KRAUTER

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

The CAUSE OF DEATH* was as follows:

Contributory
(SECONDARY)

(Signed)

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67813

CERTIFICATE OF DEATH.

D 67813

1-PLACE OF DEATH

CITY OF BALTIMORE: No. *Camp Holabird Md* ST. *1188* WARD)2-FULL NAME *2nd Lt. John M. Patton Jr.*(a) RESIDENCE. NO. *Quantico, Va* ST. WARD.

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *-*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *30 - -*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Soldier 086*(b) General nature of industry, business, or establishment in which employed (or employer) *Aviator*

(c) Name of employer

9 BIRTHPLACE (city or town) *California* (State or country)10 NAME OF FATHER *Don't know*11 BIRTHPLACE OF FATHER (city or town) *Don't know* (State or country)12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) *-* (State or country)14 Informant *W. Ashcroft Capt M.C.* (Address) *Camp Holabird Md*15 Filed *SEP 25 1922* REGISTRAR *ROBERT A. MAULDER*Burial Permit *1439*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 23 1922*17 HEREBY CERTIFY, That I attended deceased from *Sept 23, 1922*, to *Sept 23, 1922*, that I last saw him alive on *Sept 23, 1922*, and that death occurred, on the date stated above, at *1188* m.

The CAUSE OF DEATH* was as follows:

Fracture of the skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *W. Ashcroft Capt M.C.*9/23, 1922 (Address) *Camp Holabird, Md*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Lindsey Rd

20 UNDERTAKER

Jack Lewis 1439 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67814

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2510 E. Balto Street ST., 6 WARD)

2-FULL NAME

Rosa Roskman

(a) RESIDENCE No.

2510 E. Balto Street

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced. (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Layman Roskman

6 DATE OF BIRTH (month, day, and year)

1873

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant
(Address)

Jack Lewis
1439 E. Balto St

15

Filed

SEP 25 1922

ROBERT R. KARUTER

Bureau of Health

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1921 to Sept. 24, 1922, that I last saw her alive on Sept. 24, 1922, and that death occurred, on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis
General Arteriosclerosis with
Hypertension, Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Myocardial Dilatation
(duration) yrs. mos. ds. 5 min.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory findings

(Signed)

M. D. Lewis

9/24/1922 (Address) The Walbert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Heavenly Home 9-25 19 22

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Balto St

Spec. 1-10-21 M&T 1500 Bka.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67815

CERTIFICATE OF DEATH.

101-001
D 67815

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Emerson

(a) RESIDENCE NO. 1907 Ellis Ave. Alice Emerson St. ST. 7 WARD over

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of Unknown (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years Months Days If LESS than 1 day, hrs or min. 62 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) 586

(c) Name of employer

9 BIRTHPLACE (city or town) Maine (State or country)

10 NAME OF FATHER Chas. B. Emerson

11 BIRTHPLACE OF FATHER (city or town) Maine (State or country)

12 MAIDEN NAME OF MOTHER Izana Young

13 BIRTHPLACE OF MOTHER (city or town) Maine (State or country)

14 Informant Hospital Records, (Address) Municipal Hospital

15 Filed SEP 25 1922 ROBERT R. KRAUTER, Burial Permit 586

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 18 1922 to Sept. 20 1922.

that I last saw him alive on Sept. 20 1922.

and that death occurred, on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:

Lober pneumonia

(duration) yrs. mos. ds. 7

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Cul - Autopsy

(Signed) Clyde M. Neel M. D.

9/20/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (Sec reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mount Carmel Cem, DATE OF BURIAL Sept 25 1922

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Fleet St.

D 67816 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

31 D. 67816
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 N. Robinson Street ST., 6 WARD)

2-FULL NAME CHARLES MINCH

(a) RESIDENCE NO. 300 N. ROBINSON Street ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX MALE 4 COLOR OR RACE WHITE 5 Single, Married, Widowed, or Divorced, (write the word) MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ANNA MINCH

6 DATE OF BIRTH (month, day, and year) March 20th. 1852

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 70 6 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Carpenter)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Gustav Minch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Anna Minch (Address) 300 N. Robinson St.

15 Filed SEP 25 1922 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) Sept. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1922, to Sept 22, 1922, that I last saw him alive on Sept 19, 1922

and that death occurred, on the date stated above, at 2.15 P.m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) aged age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Arthur Hearn, M. D.

9/23, 1922 Address 2600 E. Baltimore Street.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Oaklawn Cemetery Sept 25, 1922

20 UNDERTAKER ADDRESS

Joseph B. Cook 1003 N. Baltimore St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67817

CERTIFICATE OF DEATH.

90 D 67817

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1216 Columbia Ave. ST. 21 WARD)

2-FULL NAME

Frances A. Peddicord

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1216 Columbia Ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 11" 1869

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
52 9 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. (State or country) Md.

10 NAME OF FATHER Austin N. Peddicord

11 BIRTHPLACE OF FATHER (city or town) Howard Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Isabelle Stanbury 9/22 (Address) 11 N. Carey St.

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co. (State or country) Md.

14 Informant Mrs. Eleanor L. Leman (Address) 1216 Columbia Ave.

15 Filed 19 ROBERT R. KRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22" 19 22

17 I HEREBY CERTIFY, That I attended deceased from 19 21 to September 22, 19 22, that I last saw him alive on September 22, 19 22, and that death occurred, on the date stated above, at 1.45 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction -

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. B. Cook, M. D.

9/22 (Address) 11 N. Carey St.

*See the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Foulson Park Cemetery

20 UNDERTAKER

Joseph B. Cook

1003 N. Bell St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67818

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Beulah E. Hepner*(a) RESIDENCE. NO. *Sykesville, Md.*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

8

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married.

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Wm. D. B. Hepner*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, *hrs.*
or *min.**39 yrs.*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Bel Air,
Md.*

10 NAME OF FATHER

John H. Bauer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland.

12 MAIDEN NAME OF MOTHER

Elia Stagner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland.

14

Informant
(Address)*Self. Wm. D. B. Hepner
Sykesville, Md.*

15

Filed

SEP 25 1922

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 25 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Sept. 17, 1922, to Sept. 25, 1922.*that I last saw her alive on *Sept. 25, 1922.*and that death occurred, on the date stated above, at *6.45 a. m.*

The CAUSE OF DEATH* was as follows:

acute appendicitis.(duration) yrs. mos. *4* ds.CONTRIBUTORY *Peritonitis & intestinal*
(Secondary) *obstruction*(duration) yrs. mos. *2* ds.

18 Where was disease contracted

if not at place of death? *Sykesville, Md.*Did an operation precede death? *Yes* Date of *9/17/22; 9/24/22*Was there an autopsy? *No.*What test confirmed diagnosis? *Physical Exam.*(Signed) *J. Willis Gentry*, M. D., 19 (Address) *University Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Sykesville, Md.**9/27/1922*

20 UNDERTAKER

Geo R. W. ...

ADDRESS

Sykesville Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Windesheim

D 67819 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO. (Usual place of abode)

Length of residence in city or town where death occurred

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed SEP 25 1922 ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 7/1922 to Sept 24, 1922 that I last saw him alive on Sept 24, 1922 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apooplexy
CONTRIBUTORY Arteriosclerosis (duration) 8 yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death? At her home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? (Signed) John J. Welch M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

D 67820

CITY OF BALTIMORE: (No. 2742 McPherson ST., 16 WARD)2-FULL NAME Baby Arnold(a) RESIDENCE NO. Same

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE Mt5 Single, Married, Widowed,
or Divorced. (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept 22/22

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or / min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)10 NAME OF FATHER Glynn M Arnold11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER Anna Newman13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant Glynn M Arnold
(Address) 2742 McPherson St

15

Filed SEP 25 1922 ROBERT R. KAUFER
Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1922

17

I HEREBY CERTIFY, That I attended deceased from
Sept 22, 1922, to Sept 22, 1922.that I last saw him alive on Sept 22, 1922.and that death occurred, on the date stated above, at 10 35 P m.

The CAUSE OF DEATH* was as follows:

Prematurity (5 mo fetus)
lived about 10 min
after birth

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) E. Smith

M. D.

Address 1005 North Av*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health.

SEP 23 1922

For Wm. B. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67821

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27422 Winchester ST. 16 WARD)

2-FULL NAME

(a) RESIDENCE NO. 27412 Winchester

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 22/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

SEP 25 1922

ROBERT R. KRAUTER

Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 22, 1922, to Sept 22, 1922.

that I last saw him live on Sept 22, 1922.

and that death occurred, on the date stated above, at 1025 m.

The CAUSE OF DEATH* was as follows:

Prematurity 5 mo fetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [Signature], M. D.

9/23/22 (Address) 1605 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health,

W. E. WOODALL

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67822

CERTIFICATE OF DEATH.

160 D 67822

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hospital* ST. *8* WARD)2-FULL NAME *Grace Isabelle Burkhardt.*(a) RESIDENCE. NO. *1842 Wattermeyer Court* ST. _____ WARD. _____

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) _____

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *April 19 1922*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *5 4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None.*(b) General nature of industry, business, or establishment in which employed (or employer) *000*

(c) Name of employer _____

9 BIRTHPLACE (city or town) *Bath* (State or country) _____10 NAME OF FATHER *Joseph A. Burkhardt.*11 BIRTHPLACE OF FATHER (city or town) *MD* (State or country) _____12 MAIDEN NAME OF MOTHER *Rose Sawman.*13 BIRTHPLACE OF MOTHER (city or town) *MD* (State or country) _____14 Informant *Joseph B. Burkhardt* (Address) *1842 Wattermeyer Ct*15 Filed *SEP 25 1922* 19 *ROBERT K. KRAUTER,* Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 23 1922*17 I HEREBY CERTIFY, That I attended deceased from *September 1st 1922* to *September 23 1922*, that I last saw him alive on *September 23 1922*, and that death occurred, on the date stated above, at *6.20 P.m.*

The CAUSE OF DEATH* was as follows:

*Marasmus.*CONTRIBUTORY (Secondary) *Pyelitis*(duration) — yrs. — mos. *25* ds.(duration) — yrs. — mos. *12* ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? *No* Date of _____Was there an autopsy? *No.*

What test confirmed diagnosis? _____

(Signed) *P. B. Price* M. D.. 19 (Address) *Union Memorial Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Western *Sept 25 1922*

20 UNDERTAKER ADDRESS

John F. Filds 1200 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 67823

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 37823) Municipal Tuberculosis Hospital ST. WARD)

2-FULL NAME Samuel T. Baker

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 19 Frederick st.
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
76

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)
(State or country) Maryland

10 NAME OF FATHER Samuel Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Connors

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland14 Informant Hospital records
(Address) H. T. U.15 SEP 25 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 19, 1922

17 I HEREBY CERTIFY, That I attended deceased from
Sept. 14, 1920, to Sept. 19, 1922.

that I last saw him alive on Sept. 19, 1922.

and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 14 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Blood, sputum, X-ray

(Signed) Francis J. Godefrides, M. D.

9-20-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

19

1922

Reason should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67824

CERTIFICATE OF DEATH.

38

D 67824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

403-N-Elm

ST., 19 WARD)

2-FULL NAME

Ada Anderson

(a) RESIDENCE No.

403-N-Elm

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 7 mos. 7 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard F. Anderson

6 DATE OF BIRTH (month, day, and year)

Oct 15, 1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

35

11

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Galeton Md

10 NAME OF FATHER

Mr. Knauer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Mr. Knauer

12 MAIDEN NAME OF MOTHER

Mr. Knauer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Mr. Knauer

14

Informant

(Address)

Howard F. Anderson
403-N-Elm

15

Filed

SEP 25 1922

ROBERT R. KAUTER

Registrar

Mortuary Permit

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) 9-21 19 22

17

I HEREBY CERTIFY, That I attended deceased from

9-1, 1922, to 9-21, 1922,

that I last saw him alive on 9-20, 1922,

and that death occurred, on the date stated above, at 54 m.

The CAUSE OF DEATH* was as follows:

Aneurysm of the ascending arch of aorta

(duration) 2 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical Exam & Ray

(Signed)

Walter J. Jones M. D.

, 19

(Address) 1618 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Auburn Cem. Sept 25 1922

20 UNDERTAKER

ADDRESS

Daniel Eaylor Beane

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Probably luetic infection
although no
Wasserman taken.*

D 67825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67825

REGISTERED NO.

1-PLACE OF DEATH

CITY OF ~~BALTIMORE~~ NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

ROBERT M. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Sept 23, 1922, to Sept 23, 1922,

that I last saw him alive on Sept 23, 1922,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH was as follows:

Fracture of the spine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Ashcraft, Capt. MC 9/23, 1922 (Address) Camp Holabird, MD

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Former* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Accidental fall
from aeroplane
down on field.*

D 67826

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Salcyon Pk. Rd.* ST. *27* WARD)

2-FULL NAME

Eliza Harriet Henry

(a) RESIDENCE NO.

Salcyon Pk. Rd. (near Hartford Rd.) ST. *27* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *67* yrs. *8* mos. *11* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 13, 1855

7 AGE

67

Years

Months

8

Days

11

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

James Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

V. Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant

Harry C. Hedeman

(Address)

Salcyon Pk. Rd. near Hartford Rd.

15

Filed

19

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 24, 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Sept 23, 1922, to Sept 24, 1922*that I last saw him alive on *Sept 23, 1922*and that death occurred, on the date stated above, at *3:30* m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Carl J. Jones*, M. D.1922 (Address) *4706 Harford av*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Landon Pk Cem

DATE OF BURIAL

Sept 26, 1922

20 UNDERTAKER

Philip's Henry

ADDRESS

2016 Orleans St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67827

CERTIFICATE OF DEATH.

D 67827

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; Lj yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Caucasian

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH.

Sept 3d, 1922

7-AGE,

yrs. mos. ds. 10

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP 25 1922

ROBERT R. KRAUTER,

Burial Form Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 20th, 1922

17- I HEREBY CERTIFY, That I attended deceased from

Sept 18th, 1922, to Sept 18th, 1922,

that I saw him alive on Sept 20th, 1922,

and that death occurred, on the date stated above at 12 M.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature S

(Signed) M. D.

(Address) 724 N. 2nd St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Laural Cemetery

DATE OF BURIAL,

Sept 25, 1922

20-UNDERTAKER

Mrs Robert A Elliott

ADDRESS

1725 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67828

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67828

1-PLACE OF DEATH

City of BALTIMORE: (No. *421 N. Central Ave* St. *5* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Donald Carnish*

(Residence in Baltimore: No. *517 East St* St.; yrs., *10* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Black* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH, *Nov 15*, 19*22* (Month) (Day) (Year)

7-AGE, *10* yrs., *8* mos., *8* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *Miner* (b) General nature of industry, business, or establishment in which employed (or employer) *ood*

9-BIRTHPLACE, (State or Country), *Balt Md*

10-NAME OF FATHER, *William*

11-BIRTHPLACE OF FATHER, (State or Country), *France*

12-MAIDEN NAME OF MOTHER, *Helma Carnish*

13-BIRTHPLACE OF MOTHER, (State or Country), *Balt Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Helma I Carnish*

(Address), *517 East St*

15-SEP 25 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 23*, 192*2* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Natural Causes - Intestinal
Ulcer - Perforation

(Duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *John H. Patton* M. D. (Coroner.) 9-23 1922 (Address) *508 E North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laural Cemetery *Sept 25*, 1922

20-UNDERTAKER, ADDRESS *1725*

Mrs RA Elliott *Wahland Ave*

D 67829 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67829

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp ST., Eastern Ave WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

4 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

4 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-22-22

17

I HEREBY CERTIFY, That I attended deceased from

9-7, 1922, to 9-22, 1922.

that I last saw him alive on 9-22, 1922.

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Diabetic gangrene left leg

(Secondary) diabetic coma (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-14-22

Was there an autopsy? No

What test confirmed diagnosis? Examination +

(Signed) Laboratory findings

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Laurel Cemetery

Sept 25 1922

20 UNDERTAKER

ADDRESS

Mrs Robert A. Elliott

2723 Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67831

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D 67831

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

15-West-29th

ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Biays Bowerman

(a) RESIDENCE. NO.

15-West-29th

ST. 12 WARD.

Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? 56 yrs. 10 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Nov-1-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56	10	21		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Henry Bowerman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Mary E. Bevan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant (Address)

Mr. Horatio Bowerman (Bro.) 15-W-29-St. City

15

Filed

1922

ROBERT A. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 22 1922

17

I HEREBY CERTIFY that I attended deceased from April 7, 1921, to Sept 22, 1922, that I last saw her alive on Sept. 22, 1922, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Recurrent carcinoma of breast

CONTRIBUTORY (Secondary)	(duration)	yrs.	mos.	ds.

(duration)	yrs.	mos.	ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of About 3 yrs ago

Was there an autopsy?

What test confirmed diagnosis?

Signed: *Frank M. Felt*, M. D.
 12-19-22 (Address) 240 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. John's P. E. Cemetery Sept 25/1922

20 UNDERTAKER

MOWEN COMPANY

ADDRESS

108 W. NORTH AVE.

D 67832

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1400 Patapsco Street. St. 23 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Nicholas Kaiser.

(Residence in Baltimore: No. 1400 Patapsco Street. St.; yrs. 70 -- 4 -- 6. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, May 16, 1952. (Month) (Day) (Year)

7-AGE, 70 yrs. 4 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Nicholas Kaiser.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Eva Junker.

13-BIRTHPLACE OF MOTHER, (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kaiser. (wife).

(Address) 1400 Patapsco St.

15-SEP 25 1922

Filed

192

ROBERT R. KRAUTER,

Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 22, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds. (Signature) Otto M. Reinhardt, M. D. (Coroner) Sept. 23 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Cedar Hill Cemetery Sep 25 1922

20-UNDERTAKER, ADDRESS

Edward J. Fanning, 1400 Patapsco St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (Write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than I day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

SEP 25 1922

ROBERT A. KAUFER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 17, 1922, to Sept 24, 1922

that I last saw him alive on Sept 24, 1922

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Branded Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James J. Melvin M. D.

19 (Address) 1303 N. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Induburn Mt.

8-25 1922

20 UNDERTAKER

ADDRESS

George H. Holland

1631 Grand Hill

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67834

CERTIFICATE OF DEATH.

D 67834

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Bertha Gager

(a) RESIDENCE. NO.

1517 N. StreetST. Balti WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph E. Gager

6 DATE OF BIRTH (month, day, and year)

Feb 1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

43

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Penn.

10 NAME OF FATHER

Edward Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pa. Penn.

12 MAIDEN NAME OF MOTHER

Susan Root

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Penn.

14

Informant (Address)

Joseph E. Gager
1517 N. Street

15

Filed

19

ROBERT A. MAUTER Registrar

Municipal Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 19 22

17

I HEREBY CERTIFY, That I attended deceased from

9-21, 1922, to 9-23, 1922,that I last saw her alive on 9-23, 1922,and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

Salpingitis, peritonitis(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-21Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) P. B. Price, M. D., 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem.

DATE OF BURIAL

Sept 25 19 22

20 UNDERTAKER

Lilly and Zeller

ADDRESS

403 N. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

STATE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

D 67835 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2027 Druid Hill Ave. 14 Ward)

2-FULL NAME John T. Willis

(Residence in Baltimore: No. 2027 Druid Hill Ave. 10 St.; yrs. mos. ds.)

D 67835
Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male 4-COLOR OR RACE colored 5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH April 1887 (Month) (Day) (Year)

7-AGE 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Laborer

9-BIRTHPLACE (State or Country). Atlanta, Ga.

10-NAME OF FATHER Frank Willis

11-BIRTHPLACE OF FATHER (State or Country). Georgia

12-MAIDEN NAME OF MOTHER. Wilkerson

13-BIRTHPLACE OF MOTHER (State or Country). Georgia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lottis Willis

(Address) 2027 Druid Hill Ave.

15-

Filed 1922

SEP 25 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept 22 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Gastritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY ac. dilatation of heart (Secondary) 5 minutes

(Signed) J. T. Hennessy, M. D. (Coroner.)

(Address) 2802 E. Lombard Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Int. Auburn Sept 25 1922

20-UNDERTAKER ADDRESS 143

John H. Toadum

STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

D 67836 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *On way to St. Joseph's Hospital* Registered No. C. *90* D 67836

City of BALTIMORE: (No. *10* St. *10* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *John J. Brannon*

(Residence in Baltimore: No. *1046 Harford Ave* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* *Single* *Married* *Widowed* *Divorced* (Write the word.)

6-DATE OF BIRTH *Apr 22 1883* (Month) (Day) (Year)

7-AGE *39* yrs. *5* mos. *3* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *Ice Dealer* (b) General nature of industry, business, or establishment in which employed (or employer) *OK*

9-BIRTHPLACE (State or Country) *Balt Md*

PARENTS.

10-NAME OF FATHER *John P Brannon*

11-BIRTHPLACE OF FATHER (State or Country) *Balt Md*

12-MAIDEN NAME OF MOTHER *Mary E. Hemming*

13-BIRTHPLACE OF MOTHER (State or Country) *Balt Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Annie A. Brannon*

(Address) *1046 Harford Ave*

15-SEP 25 1922 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept 25 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH was as follows: *Natural Causes* *Heart Disease* *probably Endocarditis* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *History of Rheumatism* (Duration) yrs. mos. ds.

(Signed) *J. H. Valler* M. D. (Coroner) *9-25 1922* (Address) *508 E. North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *New Cathedral Cemetery* DATE OF BURIAL *Sept. 28 1922*

20-UNDERTAKER *Henry Horde Son* ADDRESS *1501 E. Eager St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67837

CERTIFICATE OF DEATH.

38 D 67837

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 E Eager ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

William H. Happersett

(a) RESIDENCE NO.

1815 E Eager

ST. 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

47

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident, give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Not Known

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

about 47

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Dye cutter in

(b) General nature of industry, business, or establishment in which employed (or employer)

Caw shop

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

John B. Happersett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Sarah A. Sheeler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mr. Charles Happersett 1815 E Eager

15

Filed

SEP 25 1922

ROBERT A. K... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 23 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 12, 1922 to Sept. 23, 1922.

that I last saw him alive on Sept. 22, 1922.

and that death occurred, on the date stated above, at 9⁴⁵ A. M.

The CAUSE OF DEATH* was as follows:

Aneurysm of ascending Aorta

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edwin B. Fenley, M. D.

9/24/1922 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery

Sept 26 1922

20 UNDERTAKER

ADDRESS

Henry Hoeck Son

1301 E Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

B⁸⁴⁰⁵ 67838

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 67838

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. JOHNS HOPKINS HOSPITAL ST.,

WARD)

2-FULL NAME

Raymond Concanon

(a) RESIDENCE NO.

Texas, Md.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 11 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Male god

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Edward Concanon

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Maya & Wilhelm

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 25 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 13th, 1922, to Sept. 25th, 1922,that I last saw him alive on Sept. 25th, 1922,and that death occurred, on the date stated above, at 10¹⁵ a. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)(duration) yrs. mos. ds. 15 ds.

CONTRIBUTORY (Secondary)

Malaria

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Bacteriological

(Signed)

Horton Casparis

M. D.

19

(Address)

Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Texas Balto County Sept 25 22

20 UNDERTAKER

ADDRESS

Joseph Ahrens 2211 Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67839

CERTIFICATE OF DEATH.

113 D 67839

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 Woodyear St ST. 16 WARD)

2-FULL NAME Clarence Hardy

(a) RESIDENCE NO. 1139 Woodyear St

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

yrs. 4

mos. 28

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Benjamin Hardy

11 BIRTHPLACE OF FATHER (city or town) Charles Ca (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Courtney

13 BIRTHPLACE OF MOTHER (city or town) St Mary Co (State or country) Maryland

14 Informant Mother Mary Hardy (Address) 1139 Woodyear St

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 29 1922 to Sept 24 1922

that I last saw him alive on Sept 24 1922

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteric infection

(duration) yrs. mos. 7 ds.

CONTRIBUTORY, Artificial feeding and malnutrition (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Frank Saunders, M. D.

19 (Address) 1123 Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

Laurel Cemetery Sept 26 1922

UNDERTAKER ADDRESS

Edward Peggold 1463 7th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE
D 67840

CERTIFICATE OF DEATH.

D 67840

1. PLACE OF DEATH

Bay View Hosp.

CITY OF BALTIMORE: (No.

Eastern Ave. 16

ST., WARD)

2. FULL NAME

George Knight

(a) RESIDENCE NO.

192 Oldmonson St.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Wisconsin

10 NAME OF FATHER

Austin Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Penn

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Penn

14

Informant (Address)

Hospital Records

15

Filed

SEP 25 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9-20 1922

17

I HEREBY CERTIFY, That I attended deceased from

9-16 1922, to 9-20 1922,

that I last saw him alive on 9-20 1922,

and that death occurred, on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH* was as follows:

Ruptured appendicitis with generalized peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 9-16-22

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Richardson Jones, M. D.

19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sept 25 1922

20 UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: JOHNS HOPKINS HOSPITAL ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rev. Hugh Johnston

(a) RESIDENCE NO.

Temple Court Apts

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofEliza H. Johnston

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.82

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Pastor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Methodist Church9 BIRTHPLACE (city or town)
(State or country)Canada

10 NAME OF FATHER

Johnston John11 BIRTHPLACE OF FATHER (city or town)
(State or country)Amherst
Canada

12 MAIDEN NAME OF MOTHER

Mary Ann Leibel13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Canada

14

Informant JOHNS HOPKINS HOSPITAL
(Address)

15

Filed

19

ROBERT H. KRAUTERBurial Permit

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/24/22

17

I HEREBY CERTIFY, That I attended deceased from

8/18, 1922, to 9/24, 1922.that I last saw him alive on 9/24, 1922.and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Benign prostatic hypertrophyCONTRIBUTORY
(Secondary)(duration) 17 yrs. mos. ds.Pneumonia(duration) yrs. mos. 5 ds.

18 Where was disease contracted

if not at place of death? HomeDid an operation precede death? yes Date of 9/20/22Was there an autopsy? noWhat test confirmed diagnosis? Operation(Signed) T. P. Johnson, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALSt. Oliver

20 UNDERTAKER

H. M. Cook

DATE OF BURIAL

Sept 27 1922

ADDRESS

St. Oliver

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67843

(G. Bowne Jarvis) *Howman*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *183*)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *183*)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH. (Month) (Day) (Year)

7-AGE. *56* yrs. *2* mos. *5* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Med. doctor* (b) General nature of industry, business, or establishment in which employed (or employer). *OS*

9-BIRTHPLACE. (State or Country). *?*

PARENTS 10-NAME OF FATHER. *A. A. Jarvis* 11-BIRTHPLACE OF FATHER. (State or Country). *N. Y.* 12-MAIDEN NAME OF MOTHER. *Ella Kanary* 13-BIRTHPLACE OF MOTHER. (State or Country). *Texas*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Patterson*

(Address) *219 Northway*

15- Robert P. Harrison, Registrar.

Filed 1922 *21* Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Oct 23* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fatal shot wound of abdomen
day about (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *W. H. ...* M. D. (Address) *1659 ...*

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death *219 Northway* In the State *...* yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Grind Ridge Cemetery *Sept. 25* 1922

20-UNDERTAKER. ADDRESS

W. H. ... *805 ...*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67844

D 67844

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1637 Wilkins Ave* ST. *19* WARD)2-FULL NAME *Winifred Jennings.*(a) RESIDENCE NO. *1637 Wilkins Ave* ST. WARD (If non-resident give city or town and State)Length of residence in city or town where death occurred *23* yrs. *5* mos. *18* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

April 5, 1899

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *23* *5* *18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Coat Operator.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Greif L. & Brother.*9 BIRTHPLACE (city or town) (State or country) *Baltimore Maryland*10 NAME OF FATHER *Thomas Jennings.*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Mary Logue*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant (Address) *Catherine L. Hillen. 1637 Wilkins Ave.*15 Filed *Robert P. Harrison,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 23, 1922*17 I HEREBY CERTIFY, That I attended deceased from *March*, 1922, to *Sept.*, 1922, that I last saw her alive on *Sept. 23*, 1922, and that death occurred, on the date stated above, at *12:15 P. m.*

The CAUSE OF DEATH* was as follows:

*Pulm. Tbc.*CONTRIBUTORY (Secondary) *Endocarditis* (duration) — yrs. *6* mos. ds.(duration) — yrs. — mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No.*

What test confirmed diagnosis?

(Signed) *Sudley P. Bowie*, M. D., 19 (Address) *904 W. Charles.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*New Cathedral Cemetery Sept 26, 1922*20 UNDERTAKER *Wm. J. Hartwell* ADDRESS *2236*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified, so that it may be properly classified. See instructions on back of certificates.

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67845

1. PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Bernard Weyad

(a) RESIDENCE NO.

510 N. Pulaski St.

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

life

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6

6 DATE OF BIRTH (month, day, and year)

May 26-1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Weyad

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Rose Magaziner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15

Robert F. Harrison,

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 23 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 18, 1922, to Sept 23, 1922.

that I last saw him alive on Sept 23, 1922.

and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

TUBERCULOUS MENINGITIS

(duration) — yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Worship Circle Mt Carmel

DATE OF BURIAL

9-25-1922

20 UNDERTAKER

Jack Lewis,

ADDRESS

1439 E. Belco St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

D 67846

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67846

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.P.I. ST., 13 WARD)

2-FULL NAME

Chas. W. Blakeney

(a) RESIDENCE NO.

4021 Roland Ave ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 77 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of

WIFE of

Mrs. Chas. Blakeney6 DATE OF BIRTH (month, day, and year) April 22, 1845

7 AGE

Years 77 Months 5 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired(b) General nature of industry, business, or establishment in which employed (or employer) Mellright (Korman)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER Wm. A. Blakeney

(State or country)

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Sarah Gant

(State or country)

13 BIRTHPLACE OF MOTHER (city or town) England

(State or country)

14 Informant Mrs. Carolyn C. Blakeney(Address) 4021 Roland Ave.15 Robert P. Harrison,

Registrar

Filed 19

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1922

17 I HEREBY CERTIFY, That I attended deceased from

September 20, 1922 to Sept 24, 1922that I last saw him alive on Sept 24, 1922and that death occurred, on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Streptococcus cellulitis ofscrotum and perineumsubsequent acidosispneumonia (duration) yrs. mos. ds. 7CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 218 Where was disease contracted if not at place of death? at homeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? culture(Signed) R. P. Price M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL Hoodlawn DATE OF BURIAL Sept 26, 1922UNDERTAKER Horace H. Burge ADDRESS 3631 Hall Rd

D 67847 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67847

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2619 Hampden ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mary Anna Mitchell

(Residence in Baltimore: No. 2619 Hampden Ave. St.; 61 yrs., 11 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Female White

6-DATE OF BIRTH,

Sept. 29, 1860
(Month) (Day) (Year)

7-AGE,

61 yrs., 11 mos., 25 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Home-wife
0379-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. C. Mitchell Sr.

(Address) 2916 Hampden Ave.

15-

Filed....., 191.....

Robert P. Harrison,

Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 24, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 9, 1912, to Sept. 24, 1912,
that I saw her alive on Sept. 22, 1912,

and that death occurred, on the date stated above, at 1508 1/2

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Roscoe J. Cross M. D.

Sept. 25, 1912. (Address) 12438 Maryland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Western Cem. Sep. 27, 1912

20-UNDERTAKER

ADDRESS

Chenoweth Son & Co. Chestnut

Spec. - 1-10-21 - M&T - 1500 Bks.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

D 67848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67848

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2938 Cedar Ave ST., 13 WARD)

2-FULL NAME

Ethel V. Crue

(a) RESIDENCE NO. 2938 Cedar Ave ST.,

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

10 NAME OF FATHER John H. Crue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Ethel Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14

Informant (Address) John H. Crue
2938 Cedar Ave

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 24 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sep 13 1922, to Sep 24 1922,

that I last saw her alive on Sep 24 1922,

and that death occurred, on the date stated above, at 2 P.m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

(duration)

yrs.

mos.

12 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) R. B. Harrison

M. D.

(Address) 3547 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Marys Hospital
Chenoweth Lane Chestnut

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67849

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph's Hosp.* St. *9* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Danville Municipal Md.* St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

Married
(Write the word.)

6-DATE OF BIRTH.

Dec

31

1856

(Month)

(Day)

(Year)

7-AGE

65

8

mos.

24

ds.

If LESS than 1 day,

.....hrs. or.....min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

Grocery
Merchant

9-BIRTHPLACE,
(State or Country).

Ann Arundel Co Md

10-NAME OF FATHER.

Thomas King

11-BIRTHPLACE OF FATHER,
(State or Country).

Md

12-MAIDEN NAME OF MOTHER.

Barbara Deane

13-BIRTHPLACE OF MOTHER,
(State or Country).

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edward W King

(Address)

Danville Md (Nephew)

15.

Robert P. Harrison,

1922

1922

Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

18

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Autopsy* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Autopsy* find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stenocardia of
coronary (Artery)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) *J. H. Hall* M. D.

9-25-22 (Address) *508 E North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Ann Arundel Co Md

Sept 25, 1922

20-UNDERTAKER,

ADDRESS

Geo M. Fink

511 N Wolfe

Physicians should state EXACTLY. Exact statement of Occasion of Death is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

D 67850

HEALTH DEPARTMENT CITY OF BALTIMORE

D 67850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Skennedon St. 1 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Yajko

(a) RESIDENCE No. 1005 Skennedon St. 1 WARD (Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24-1879

7 AGE Years 43 Months 3 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Poland (State or country)

10 NAME OF FATHER Ignacy Yajko

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Amelia Yajko (Address) 1005 Skennedon St. Ave

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 24 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1922, to Sept 22 1922, that I last saw him alive on Sept 22 1922, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? San Francisco

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. M. Juley, M. D.

(Address) 2938 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Stanislaus Cemetery

20 UNDERTAKER Stephen J. Jackowski

DATE OF BURIAL Sept 26 1922 ADDRESS

Burial Permit Clerk.

D 67851

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67851

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Morrow Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

1122 Mount

ST.,

WARD)

2-FULL NAME

Theodore Pasquel

(a) RESIDENCE NO.

None

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant Marine

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Peru

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Morrow Hosp. Records

15

Filed

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/24 1922

17

I HEREBY CERTIFY, That I attended deceased from

8/4, 1922, to 9/24, 1922,

that I last saw him alive on

9/24, 1922,

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration)

yrs. 4

mos.

ds.

CONTRIBUTORY (Secondary)

Hemorrhage

(duration)

yrs. 1

mos.

ds.

18 Where was disease contracted

if not at place of death?

Unknown

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Microscopic exam of sputum

(Signed)

P. E. Schoole, M. D.

9/24, 1922 (Address)

1122 Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Trinity Hospital

20 UNDERTAKER

J. Garrison - Br.

DATE OF BURIAL

9/25 1922

ADDRESS

427 E. Baltimore

D 67853

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67853

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2524 Fleet St. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Salomon Joseph Brill(a) RESIDENCE NO. 2524 Fleet ST., 1 WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) S5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept 27, 1922
7 AGE Years Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.10 NAME OF FATHER Salomon J. Brill11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pennsylvania12 MAIDEN NAME OF MOTHER Anna Brill13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14

Informant
(Address) J. Lewis
1439 5th St. Baltimore

15

Filed SEP 26 1922

ROBERT A. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/25 192217 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1922, to Sept 25, 1922,
that I last saw him alive on Sept 25, 1922,
and that death occurred, on the date stated above, at 4 m.
The CAUSE OF DEATH* was as follows:
Acute Myocardial Infarction

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Blanche M. D.9/26 1922 (Address) 3325 Park Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOYAL

Rehman Fremont Co.9/26 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 5th St.Baltimore

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67854

CERTIFICATE OF DEATH.

D 67854

1-PLACE OF DEATH

CITY OF BALTIMORE: *215 Gittings Ave* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Fannie Madsen*(a) RESIDENCE. NO. *215 Gittings Ave* ST. *4* WARD.Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *H^m Madsen*6 DATE OF BIRTH (month, day, and year) *Mar. 2/1840*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *81 10 22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt.*10 NAME OF FATHER *John Mehl*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Oril-Kum*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *William Madsen* (Address) *215 Gittings Ave*15 Filed *SEP 25 1922* 19 *ROBERT P. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept-24 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept. 20*, 19*22*, to *Sept 24*, 19*22*, that I last saw him alive on *Sept. 24*, 19*22*, and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration) *6* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*What test confirmed diagnosis? *Post-mortem*(Signed) *M. Gibson* M. D.Address *422 Roland Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Presbyterian Graves *Sept-27 1922*

20 UNDERTAKER

Wm Corle ADDRESS *H. S. Mt.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67856

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154 D 67856

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2522 E Cager Place ST. 7 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 2522 E Cager Place ST. 7 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

9

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Sept 17/22

7 AGE

Years

Months

Days

9

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

T. G. Cepol

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Emma Sandy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

T. G. Cepol
2522 E Cager Place

15

Filed

19

ROBERT A. KRAUTER
Registrar

Surgeon General's Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 26 1922

17

HEREBY CERTIFY, that I attended deceased from

Sept 12 1922 to Sept 26 1922 that I last saw him alive on

and that death occurred, on the date stated above, at 3:30 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration)

yrs.

mos.

9

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

What test confirmed diagnosis?

Findings

(Signed)

Fred H. H. H. M. D.

19

(Address) 800 N. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Sept 26 1922

20 UNDERTAKER

Paul Brachman

ADDRESS

1806 E. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 26 1922

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67857

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *15* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2201 Poplar Grove St* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

white

5-Single, Married, Widowed, or Divorced.

Married
(Write the word.)

6-DATE OF BIRTH.

April 20 1866
(Month) (Day) (Year)

7-AGE.

56 yrs. 5 mos. 3 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Lack wacker*
(b) General nature of industry, business, or establishment in which employed (or employer). *17 B & O R.R.*

9-BIRTHPLACE.

(State or Country). *MD*

10-NAME OF FATHER

Audrey Schlaubly

11-BIRTHPLACE OF FATHER.

(State or Country). *Germany*

12-MAIDEN NAME OF MOTHER.

May E. Smith

13-BIRTHPLACE OF MOTHER.

(State or Country). *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joe Sheafman*

(Address) *2201 Poplar Grove St*

15-

Filed *SEP 26 1922* 192 *ROBERT A. KRAMER*

Bureau Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 23 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*

and that said deceased came to *his* death (Cause of death.)

on the day stated above.

The CAUSE OF DEATH was as follows:

Fractured Skull, traumatic asphyxia, hemorrhage, shock

(Duration) *a few hours* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Struck by B & O R.R. engine*

(Duration) *1 hr* yrs. mos. ds.

(Signed) *H. H. Gough* M. D.

(Coroner.) *9:26 1922* (Address) *47 W. Saratoga St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former usual residence

19-PLACE OF BURIAL OR REMOVAL.

Elkridge Md DATE OF BURIAL *9/26/22*

2-UNDERTAKER

W. J. Johnson Son ADDRESS *Reverend North Dr*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 D 67858

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Bertha Sze

(a) RESIDENCE NO.

618 Wayne St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 16 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl(b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer 9 BIRTHPLACE (city or town) (State or country) Newland10 NAME OF FATHER William Sze11 BIRTHPLACE OF FATHER (city or town) (State or country) Newland12 MAIDEN NAME OF MOTHER Louise13 BIRTHPLACE OF MOTHER (city or town) (State or country) 14 Informant JOHNS HOPKINS HOSPITAL (Address) 15 Filed SEP 26 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 192217 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1922, to Sept 23, 1922, that I last saw her alive on 2, 1922,and that death occurred, on the date stated above, at 4 PM m.

The CAUSE OF DEATH* was as follows:

Tuberculosis MeningitisAbout 3 weeks (duration) yrs. mos. ds.CONTRIBUTORY Tuberculous pneumonia (Secondary) (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? Fort BraggDid an operation precede death? No Date of Was there an autopsy? YesWhat test confirmed diagnosis? (Signed) C. Bowles Andrus, M. D., 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Interment Cemetery DATE OF BURIAL Sept 26 192220 UNDERTAKER Mrs. G. H. Hoffer ADDRESS 406 W. Conway St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67859 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 1007
D 67859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital 24 Ward)

Registered No. C.....

2-FULL NAME Robert W. E. Carter. (C).

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. Marley A. A. Co. Md. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, Single. (Write the word.)

6-DATE OF BIRTH, Do not know. (Month) (Day) (Year)

7-AGE, 34 yrs. -- mos. -- ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Adam Carter (C).

11-BIRTHPLACE OF FATHER, (State or Country), A. A. Co Md.

12-MAIDEN NAME OF MOTHER, Charlotte Johnson. (C)

13-BIRTHPLACE OF MOTHER, (State or Country), A. A. Co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Carter. (C) (father).

(Address) Marley A. A. Co. Md.

15- SEP 26 1922 ROBERT R. KRAUTER, Registrar

Filed SEP 26 1922 Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 23, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushed about the limbs by the accidental falling of a piece of machinery, Amputation of the leg.

(Duration) yrs. mos. ds. shock.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Otto M. Reinhardt, M. D. (Coroner.) Sept. 26, 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? Davison Chemical Co. Curtis Bay. Former place of residence, September 23, 1922.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Furnace Branch, 9/26/22 1922

20-UNDERTAKER, ADDRESS

Jas. M. Skinner 1625 E. Madison St

D 67860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67860

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 S Washington ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Kroppa(a) RESIDENCE NO. 606 S Washington ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) July 16 19227 AGE Years Months Days If LESS than 1 day, hrs or min.
2 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Adam Kroppa11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)12 MAIDEN NAME OF MOTHER Mary Labedzinski13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)14 Informant Mr Adam Kroppa

(Address)

15 Filed SEP 26 1922 ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 25 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sep 3 1922, to Sep 26 1922that I last saw him alive on Sep 26 1922and that death occurred, on the date stated above, at 830 P m.

The CAUSE OF DEATH* was as follows:

Myocardium

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Miller, M. D.19 (Address) #22 Boring

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

St Stanislaus Sep 26 1922

20 UNDERTAKER ADDRESS

John M. Weber 1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67861

CERTIFICATE OF DEATH.

D 67861

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Wid.

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Martha Ketchum

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

15

Filed

19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 19, 1922 to Sept 23, 1922.

that I last saw him live on Sept 23, 1922.

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luke McNeil, M. D.

19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Oaklawn Cemetery

20 UNDERTAKER

Gibbler + Gibbler

DATE OF BURIAL

Sept 26 1922

ADDRESS

1739 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT P. KAUTER

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67862

CERTIFICATE OF DEATH.

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *76* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)*Female white Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Robert Wallis*

6 DATE OF BIRTH (month, day, and year)

Aug 7, 1861

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*61**1**16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

*Housewife*9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)*Robert Wallis*
3203 Eastern Ave

15

Filed

SEP 26 1922
ROBERT H. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 14, 1922

17

I HEREBY CERTIFY, That I attended deceased from
Sept 22, 1922 to *Sept 24, 1922*that I last saw him alive on *Sept 24, 1922*and that death occurred, on the date stated above, at *12:30 p.m.*

The CAUSE OF DEATH* was as follows:

*Cancerous Stomach*CONTRIBUTORY (duration) yrs. *1*, mos. *1*, ds.(Secondary) (duration) yrs. *1*, mos. *1*, ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *yes* Date of *Sept 23, 1922*Was there an autopsy? *no*What test confirmed diagnosis? *operative*(Signed) *J. S. [Signature]* M. D., 19 (Address) *Mary Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Mt. Carmel
*Jickler & Jickler**Sept. 28, 1922*
1739
Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67863

CERTIFICATE OF DEATH.

D 67863

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Fairmount Ave ST., 6th WARD)

2-FULL NAME

Solomon Uhlfelder

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1922 Fairmount Ave ST., 6th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced

HUSBAND of

Harriet E. Uhlfelder

6 DATE OF BIRTH (month, day, and year)

Dec. 20, 1844

7 AGE

77

Years

9

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fire Dept. Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

032

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Jacob Uhlfelder

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Hannah Kline

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Jos. J. Uhlfelder
6037 N. Rose St

15

Filed

19

ROBERT B. SMITH
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25, 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 11, 1922, to Sept 25, 1922, that I last saw him alive on Sept 20, 1922, and that death occurred, on the date stated above, at 4:10 A m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Smith, M. D., 19 (Address) 22 N. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hebrew BurialSept. 28, 1922

20 UNDERTAKER

ADDRESS

J. J. JicklerEager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

✓ D 67865

96

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

CORONER'S CERTIFICATE OF DEATH

5-Single, Married, Widowed, or Divorced. (Write the word.)

..... 1

(Month) (Day) (Year)

If LESS than 1 day,
....hrs. or....min.?

Trailer 070

1.

James Smith

msd'

ME W. H. K.

1 1 1 1

IS TRUE TO THE BEST OF MY KNOWLEDGE

Alameda, Norfolk

762 H Dardlogatz

10/10/10

192

Name _____

Sept 22, 1922
(Month) (Day) (Year)

TIFY, That I took charge of the
.....
(Inquest, autopsy or inquiry.)
.....
obtained by said
.....
deceased came to *his* death

The CAUSE OF DEATH* was as follows:

Retrolental Fibroplasia

(Duration) 10:00

Don't know

(Duration) yrs mos ds

(Signed) W. J. Jones M. D.
(Coroner)

9124 1922 (Address) 113 W. Vine St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Laurel Kennedy Sept 26, 2

20-UNDEERTAKER

578

D 67866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: JOHNS HOPKINS HOSPITAL ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Waters

(a) RESIDENCE NO.

644 Greenwillow ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 1 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female BlackSingle5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 5 - 1905

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.17120

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Maryland

10 NAME OF FATHER

Elijah Waters

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

md

12 MAIDEN NAME OF MOTHER

Henrietta Distance

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md

14

Informant JOHNS HOPKINS HOSPITAL

(Address)

15

Filed SEP 26 1922 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1922

17

I HEREBY CERTIFY, That I attended deceased from
Sept 24, 1922 to Sept 25, 1922
that I last saw her alive on Sept 25, 1922and that death occurred, on the date stated above, at 3:45 p. m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis ruptured(duration) yrs. mos. 8 ds.CONTRIBUTORY Generalized acute peritonitis
(Secondary)(duration) yrs. mos. ? ds.18 Where was disease contracted
if not at place of death? at residenceDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? autopsy findings(Signed) Dr. Clyde A. Stratton, M. D., 19 (Address) Johns Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Samuel Rogers9/28 1922

20 UNDERTAKER

ADDRESS 578Samuel Rogers Bedale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67867
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3808 Worcester Rd. ST. 15 WARD)

2-FULL NAME

Araminta Josephine Judefin

(a) RESIDENCE No.

3808 Worcester Rd.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

6

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 67867

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 13 - 1840

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

82

6

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Kent - Co

10 NAME OF FATHER

Alexander Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Kent

Co Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

H. B. Judefin
1200 1st St. N. W.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9. 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

9. 23 1922, to 9 - 24 1922,

that I last saw her alive on 9 - 24 1922

and that death occurred, on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum negative

(Signed) M. D.

9. 25 1922 (Address) 341 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Romain Cemetery

Sep 27 1922

20 UNDERTAKER

George Smith

ADDRESS 1000

H. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67868

CERTIFICATE OF DEATH.

67868

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Fremont Ave. ST. 18 WARD)

2. FULL NAME Florence May Phillips

(a) RESIDENCE No. 508 N. Fremont Ave. ST. WARD

(Usual place of abode)
Length of residence in city or town where death occurred Days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Ralph T. Phillips
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11-1873

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
49 7 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

10 NAME OF FATHER Frederick T. Murray

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Christiana Fresh 9-26, 1922 (Address) 508 N. Fremont Ave

13 BIRTHPLACE OF MOTHER (city or town) Balt. City
(State or country)14 Informant Ralph T. Phillips
(Address) 508 N. Fremont Ave

15 Filed SEP 25 1922 Registrar George Smith

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1922, to Sept 25, 1922, that I last saw her alive on Sept 25, 1922, and that death occurred, on the date stated above, at 10.30 A. m. The CAUSE OF DEATH* was as follows:
Apoplexy 4 1/2 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 67869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67869

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 E. Fayette ST.; 19 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1527 E. Fayette St.; 30 yrs., mos., da.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

C

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Unknown

(Month) (Day) (Year)

7-AGE,

approx 60

yrs. — mos. — da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9-BIRTHPLACE,

(State or Country),

Worcester Co Md.

10-NAME OF FATHER,

Moses Shaper

11-BIRTHPLACE OF FATHER

(State or Country),

Md.

12-MAIDEN NAME OF MOTHER

Annie Jones Thomas

13-BIRTHPLACE OF MOTHER

(State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nettie Jefferson(Address) 1527 E. Fayette St.

15-

Filed SEP 23 1922

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 22, 1922

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 28 1922, to Sept 22 1922,that I saw her alive on Sept 21 1922and that death occurred, on the date stated above, at 6:50 p.m.

The CAUSE OF DEATH* was as follows:

Cardio-Neuritisto my family(Duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.(Signed) R. J. Young M. D.9/23, 1922 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Laurel CemeterySept. 26, 1922

20-UNDERTAKER

ADDRESS

Mrs Robert A. Elliott1725 - Ashland Ave

Specimen of death certificate. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67870

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3)

JOHNS HOPKINS HOSPITAL ST. 3

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Mary Chaney

(a) RESIDENCE NO.

221 S. Bethel St. City

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 years

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year)

1926

7 AGE

46

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House job

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

James Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Anne Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed SEP 25 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 23 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 15 1922 to Sept 23 1922

that I last saw her alive on Sept 23 1922

and that death occurred, on the date stated above, at 8:00 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, arteriosclerosis, hypertension, chronic nephritis, Terminal bilateral bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. Bowles Andrews M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel

20 UNDERTAKER

A. B. Cross 1405 MOELderry

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67871

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 11 WARD)2-FULL NAME Jarome Madden

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 419 State St.
(Usual place of abode)ST., 11 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18517 AGE Years 71 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040 Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)10 NAME OF FATHER Paul Madden11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.12 MAIDEN NAME OF MOTHER Mary Johnson13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14

Informant Hospital Records
(Address) Municipal Hospital

15

Filed SEP 26 1922 ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept. 19, 19 22, to Sept. 25, 19 22, that I last saw him alive on Sept. 24, 19 22, and that death occurred, on the date stated above, at 4:30 A.M. m.

The CAUSE OF DEATH* was as follows:

Coronary insufficiency(duration) yrs. 6 mos. ds.

CONTRIBUTORY

(Secondary)

Myocardial insufficiency (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Moncrief M. D.9/25/22 Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Asbury
R. B. Gross 1405 McElderry

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67872

HEALTH DEPARTMENT—CITY OF BALTIMORE

67872

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 Edmondson Ave. ST. 19 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles W. Hynes

6 DATE OF BIRTH (month, day, and year)

Mar 29-1838

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

5

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Catonsville Md

10 NAME OF FATHER

Ferdinand Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Catonsville Md

12 MAIDEN NAME OF MOTHER

Mary Ann Herbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa

14

Informant (Address)

Charles H. Hynes 3412 Duwall Ave.

15

Filed

19

ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 24, 1922, to Sept 25, 1922,

that I last saw her alive on Sept 25, 1922,

and that death occurred, on the date stated above, at 1150 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration)

mos 1 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL

DATE OF BURIAL

London Park

Sept 28 1922

20 UNDERTAKER

ADDRESS

John Outchell 1201 W. Fayette St

Exact statement of OCCUPA-

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67873

CERTIFICATE OF DEATH

D 67873

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2101 St Paul ST. 12 WARD)

2 FULL NAME Millard Law Perkins

(Residence in Baltimore: No. 2101 St Paul St

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: 47 yrs. 10 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6 DATE OF BIRTH November 19, 1874 (Month) (Day) (Year)

7 AGE 47 yrs. 10 mos. 6 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Salesman (b) General nature of industry, business, or establishment in which employed (or employer) Silk mills

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Geo. H. C. Perkins

11 BIRTHPLACE OF FATHER (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nannie S. Vinton

13 BIRTHPLACE OF MOTHER (State or country) Gladesburg Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

SEP 26 1922

ROBERT A. KRAUTER,

Bureau Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH September 25, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1922, to Sept. 25, 1922, that I saw him alive on Sept. 25, 1922, and that death occurred, on the date stated above, at 3 P. m. The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(Duration) 3 yrs. mos. ds. Contributory (SECONDARY) Myocardial infarction

(Signed) H. B. M. Egan M. D. (Address) 31-E North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

McGowan Company

108 W. NORTH AVE

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67874

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 W. Lexington ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY FARRELL(a) RESIDENCE. NO. 1503 W. Lexington ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female WhiteSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1839

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

abt. 83

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Chelmsford

10 NAME OF FATHER

Matthew Farrell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Chelmsford

12 MAIDEN NAME

Ruddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Chelmsford

14

Informant (Address)

Mrs. Bertha Summers
939 W. Lexington St

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 22 1922, to Sept 25 1922, that I last saw her alive on Sept. 23 1922, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pericarditis(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Auricular fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical signs(Signed) W. H. Triplett M. D.9/26/22 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemetery

DATE OF BURIAL

Sept. 27 1922

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 W. Calhoun St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67875

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mt Hope Retmas

ST. 28th WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jm Roelin

(a) RESIDENCE. NO.

Mt Hope Retmas - Patients ST. 28th WARD.

York Pa.

(Usual place of abode)

Length of residence in city or town where death occurred

0 yrs. 0 mos. 4 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or WIFE of)

Mrs Roelin

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

abt 46

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

Painting -

(c) Name of employer

York Pa

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not Known

14

Informant (Address)

Records of Mt Hope Retmas

15

Filed

Robert F. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 26th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 22nd - 1922, to Sept 26th - 1922,that I last saw him alive on Sept 25th - 1922,

and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Not known here - Probably for some years - 2 or 3 perhaps -

CONTRIBUTORY (Secondary)

Acute mania

abt 4 or 5 days

18 Where was disease contracted if not at place of death?

York Pa

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

26th 1922 (Address) Mt Hope Retmas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

York Pa

DATE OF BURIAL

Sept 26 1922

20 UNDERTAKER

Wm Cook

ADDRESS

502 E Park

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Parish ST., 19 WARD)

2. FULL NAME

(a) RESIDENCE NO. 514 Parish ST., 19 WARD

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

(or) WIFE of Buck Campbell6 DATE OF BIRTH (month, day, and year) Mar 14, 18997 AGE Years 23 Months 5 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balts (State or country) md10 NAME OF FATHER Walter Brown11 BIRTHPLACE OF FATHER (city or town) md (State or country) Brown12 MAIDEN NAME OF MOTHER Nannie Johnson13 BIRTHPLACE OF MOTHER (city or town) Balts (State or country) md

14

Informant Nannie Johnson (Address) 514 Parish St

15

Filed

19

ROBERT A. MAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 23 1922

17 I HEREBY CERTIFY, That I attended deceased from

June 15, 1922 to Sept 23, 1922.that I last saw her alive on Sept 20, 1922and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis(duration) yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Urinary
(Signed) E. William Frey, M. D.9/2, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOV. Mt Zion Cem.

DATE OF BURIAL

Sept 27th 1922

20 UNDERTAKER

A. Jones

ADDRESS

1112 Schmitz St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 67877

HEALTH DEPARTMENT—CITY OF BALTIMORE

H 4 D 67877

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *410 Font Hill* ST.: *20* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Katherine Shipley*(a) RESIDENCE. NO. *410 Font Hill* ST. *20* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of *Joseph Shipley*6 DATE OF BIRTH (month, day, and year) *May 14 1867*7 AGE *55* Years Months *4* Days *10* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md*

(State or country)

10 NAME OF FATHER *Christoph Gent*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*14 Informant *Estella Johnson*(Address) *410 Font Hill Ave.*15 Filed *Robert P. HARRISON*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 24* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Aug 1, 19 *22*, to *Sept 22*, 19 *22*.that I last saw him alive on *Sept 23*, 19 *22*.and that death occurred, on the date stated above, at *5-P* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis? *Physical Findings*(Signed) *W. A. Kell*, M. D.*9/24*, 19 *22* (Address) *Livingstone*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

Sept. 27 19 *22*

20 UNDERTAKER

B. W. Dill

ADDRESS

3109 Fredk. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P 26-1922

Burial Permit Clerk

D 67878

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1600 E Chase ST., 8 WARD)

2-FULL NAME

Annie E Litman

(a) RESIDENCE NO.

1600 E Chase

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 22nd 1867

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

55

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

School Teacher

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Public Schools

(c) Name of employer

Balto City

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md

10 NAME OF FATHER

Thomas Litman

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto
Md

12 MAIDEN NAME OF MOTHER

M. Louisa Hopton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto
Md

14

Informant

(Address)

Mary Cecelia Litman
357 Harrison Ave

15

Filed

Robert P. Harrison,

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 20 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 15, 19 22, to Sept 20, 19 22,
that I last saw him alive on Sept 27, 19 22

and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Atherosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)Cerebral Hemorrhage
(duration) 1 yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Walker, M. D.

(Address) 1228 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Greenmount Cemetery

DATE OF BURIAL

Sept 27 19 22

20 UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monument

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

P2 1922

Burial Permit Clerk.

D 67879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67879

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *9* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1629 Enoch Ave* St.; yrs. *30* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH

*Oct**11**1889*

(Month)

(Day)

(Year)

7-AGE

32

yrs.

11

mos.

15

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION

(a) Trade, profession, or particular kind of work. *Electrician*
(b) General nature of industry, business, or establishment in which employed (or employer) *679*

9-BIRTHPLACE

(State or Country) *Germany*

10-NAME OF FATHER

Louis E Lent

11-BIRTHPLACE OF FATHER

Germany

12-MAIDEN NAME OF MOTHER

Matilda A Lent

13-BIRTHPLACE OF MOTHER

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Elsie C. Lent

(Address)

1629 Enoch Ave

15-

Filed

1922

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

*Sept**24**1922*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* *held by**at 5:30 P.M.* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* *and*and that said deceased came to *death*

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

*Fract skull &**skull by auto truck on 20th**and Calvert St. 5 days*CONTRIBUTORY *inquest will be held tonight*(Secondary) *Duration* yrs. mos. ds.(Signed) *W. H. B. B. B.* M. D.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place *15 minutes* In the

of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

*Baltimore Cemetery*DATE OF BURIAL *Sept 28th 1922*

20-UNDERTAKER

*George Schilling Sons**146 E Monument St*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67880

185 D 67880

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *17* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Benjamin Gray*

(Residence in Baltimore: No. *730 N. Greeley St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Csks

5-Single, Married, Widowed or Divorced (Write the word.) *Married*

6-DATE OF BIRTH

Don't Know

7-AGE

65

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Labourer

9-BIRTHPLACE, (State or Country).

Md.

10-NAME OF FATHER

Henry Gray

11-BIRTHPLACE OF FATHER, (State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Caroline Hall

13-BIRTHPLACE OF MOTHER, (State or Country).

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Benjamin Gray
730 N. Greeley St.

15-

Robert F. Harrison

Filed

1922

Benjamin Gray

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept

25

1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or Inquiry.) find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

CONTRIBUTORY (Secondary)

Inhaled to shortly from top

(Duration) yrs. mos. ds.

(Signed)

J. H. Harrison

Sept 25, 1922 (Address) *117 N. Greeley St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Brooks Chapel

Sept 27, 1922

20-UNDERTAKER

John H. Tradum

ADDRESS

142 W. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67881

CERTIFICATE OF DEATH.

67881

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cleveland Brown(a) RESIDENCE NO. 682 Barracks, Sparrows Point ST.,WARD Sparrows Point

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. Now long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19247 AGE Years Months Days If LESS than 1 day, hrs or min. 18 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records, (Address) Municipal Hospital.15 Filed Robert P. Harrison, 19 20 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 20 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept. 16, 19 22, to Sept. 20, 19 22, that I last saw him alive on Sept. 19, 19 22, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

14 pharyngeal feverCONTRIBUTORY (Secondary) Intestinal Hemorrhage (duration) yrs. mos. ds. 10(duration) yrs. mos. ds. 10

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Aut. Blood Culture (Signed) Clyde McNeil M. D.9/21/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Johnson StationSept 26, 22UNDERTAKER Buckingham CoADDRESS 142John H. Treadwellunder

Exact statement of OCCUPATION should be carefully supplied. NOTE amount to stated on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Stanislawa Kurgan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67882

D 67882

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 S. Port

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Stanislawa Kurgan

(a) RESIDENCE. NO.

629 S. Port

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

FEMALE

WHITE

SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) BALTIMORE (State or country)

10 NAME OF FATHER FRANK KURGAN

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

POLAND

12 MAIDEN NAME OF MOTHER MARYANNA KRAWCZYK

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

POLAND

14 Informant Mr. Frank Kurgan (Address) 629 S. Port St.

15 Filed

SEP 27 1922

ROBERT A. KRAVITZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1/1 26 19 22

17

I HEREBY CERTIFY, That I attended deceased from

1/1 27 1922, to 1/1 26 19 22

that I last saw him alive on 1/1 26 19 22

and that death occurred, on the date stated above, at A m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1/1 26 19 22 (Address) John H. Bremer, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOLY ROSARY

SEP 27 1922

20 UNDERTAKER

ADDRESS

John H. Bremer 1803 Bay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67883

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

160

D 67883

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2137 ✓) *Sturtevant*

ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Edmund C. Lee*(a) RESIDENCE. No. 2137 *Sturtevant*.
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *Life* How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,

or Divorced (write the word)

*Single*3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *June 13-22*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*3**13*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*none*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore City*10 NAME OF *Edmund C. Lee*

PARENTS

11 BIRTHPLACE OF FATHER (city or town)
(State or country)*York*12 MAIDEN NAME OF MOTHER *Edith Green*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Pa.*

14

Informant *Charles E. Lee*
(Address) *2137 Sturtevant St*

15

Filed *SEP 27 1922* 19 *ROBERT A. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *9-26 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*June 13 1922, to Sept 26, 1922*that I last saw him alive on *Sept 25, 1922*and that death occurred, on the date stated above, at *7:45 a.m.*

The CAUSE OF DEATH* was as follows:

Marasmus
(*Marasmus*)(duration) yrs. *2* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. H. C. Lee M. D.
9/26/22 (Address) *2737 W. North Ave**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery *Sept 27, 1922*

TO UNDERTAKER

ADDRESS

Lorain Syper 1600 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No gastro enteritis
Weakling since birth & bad
poor surroundings

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67884

CERTIFICATE OF DEATH.

127 D 67884

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635 archer st 21

ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 635 archer st

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Cvl

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary Hall

6 DATE OF BIRTH (month, day, and year) Dec 25-1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49-

8

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labarer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md

(State or country)

10 NAME OF FATHER

John Hall

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore md

12 MAIDEN NAME OF MOTHER Anne Withers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore md

14

Informant (Address)

Mary R. Hall 635 archer st

15

Filed

19

ROBERT A. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 22, 1922, to Sept 24, 1922,

that I last saw him alive on Sept 24, 1922,

and that death occurred, on the date stated above, at 7 PM.

The CAUSE OF DEATH* was as follows:

Hypertrophic Cardiomyopathy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Ephemeris

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. H. Claude, M. D.

1504 McCulloch St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Anthony's

Sept 27 1922

20 UNDERTAKER

ADDRESS

Wm. H. Chase & Son

1400 Mosher

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67885

CERTIFICATE OF DEATH.

88 D 67885

1-PLACE OF DEATH

5-13 S. Spring St.

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Bertha Miller

(Residence in Baltimore: No.

5-13 S. Spring St.

St.;

3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Black

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widow

6-DATE OF BIRTH,

Unknown

1

(Month)

(Day)

(Year)

7-AGE,

37

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,

(State or Country),

Born in Kent Co Md

10-NAME OF FATHER,

John Boomer

11-BIRTHPLACE OF FATHER

(State or Country),

Kent Co Md

12-MAIDEN NAME OF MOTHER

Sarah Sweeney

13-BIRTHPLACE OF MOTHER

(State or Country),

Kent Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Alease Miller

(Address)

5-13 S. Spring St

15-

Filed

SEP 27 1922

101

ROBERT R. KRAUTER

Baltimore Health Dept. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept

25

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 5 1922, to Sept 25 1922,

that I saw him alive on Sept 24 1922,

and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Endocarditis

(Duration) yrs. 5 mos. ds.

(Signed)

Eugene W. Phillips M. D.

Sept 25, 1922 (Address) 1735 Ashland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Still Pond and Kent Co

Sept 27, 1922

20-UNDERTAKER

ADDRESS

Mrs Robert A. Elliott

1735 Ashland Ave

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67886

CERTIFICATE OF DEATH.

38 D 67886

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 William ST. 24 WARD)

2-FULL NAME

Marie Lilian Goldsmith

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1004 William ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 46 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Jesse Goldsmith

11 BIRTHPLACE OF FATHER (city or town) Baltimore Maryland (State or country)

12 MAIDEN NAME OF MOTHER Annie F. Figg

13 BIRTHPLACE OF MOTHER (city) Cumberland Maryland (State or country)

14 Informant Mr. Jesse Goldsmith (Address) 11004 William St

15 Filed SEP 27 1922 ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9.27. 1922

17 I HEREBY CERTIFY, That I attended deceased from 9.12.22, 19, to 9.27.22, 19

that I last saw her alive on 9.26.22, 19

and that death occurred, on the date stated above, at 2.4. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

8 mo. gestation (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital Puer (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical only

(Signed) P. Hilig S. Fowler M. D.

9.27.22 (Address) 1492 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross aac ma

DATE OF BURIAL

Sept 27 1922

20 UNDERTAKER

John F. Denny

ADDRESS

715 L. St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67887

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 182 West CrossST. 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Goodman:(a) RESIDENCE. No. 162 West Cross.

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29 18647 AGE Years 58 Months 2 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.10 NAME OF FATHER William Seymour

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.12 MAIDEN NAME OF MOTHER Anna Myers.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.14 Informant Carrie Seymour(Address) 182 West Cross St.15 Filed SEP 27 1922ROBERT R. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 25 192217 I HEREBY CERTIFY, That I attended deceased from July 20, 1922, to Sept 25, 1922, that I last saw him alive on Sept 25, 1922.and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chorea
Leucorrhoea
(duration) yrs. 2 mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) R. H. Campbell M.D.
Sept 25 1922 (Address) 1644 Hancock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill CemeterySept. 28 1922

20 UNDERTAKER

ADDRESS

Mrs. J. Evans Sons 1428 S. Charles St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67888

D 67888

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

Mercy Hospital

St.

Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Lillian Smaellwood

(Residence in Baltimore: No.

120 Allman St.

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Col

5-Single,

Married,

Widowed,

or Divorced,

(Write the word.)

Married

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

36

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

Ind.

PARENTS.

10-NAME OF FATHER.

James Jolley

11-BIRTHPLACE OF FATHER.

(State or Country).

Ind.

12-MAIDEN NAME OF MOTHER.

Ind.

13-BIRTHPLACE OF MOTHER.

(State or Country).

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Lillian Smaellwood

(Address)

120 Allman

15

SEP 27 1922

ROBERT R. KRAUTER

Filed

By

Bureau Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 21

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Spleen

Duration

(Duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(Signed)

(Duration)

yrs.

mos.

ds.

(Address)

(Coroner)

M. D.

1922

(Address)

1039 B

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Asbury

Sept 27, 1922

20-UNDERTAKER.

ADDRESS

John W. Henderson

Emmott

*Not cancerous. No accident.
Hemorrhage stomach due to chronic nephritis.*

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, Hemorrhage, Meningitis, Phlebitis, Cellulitis, Gangrene, Miscarriage, Pyemia, Childbirth, Gastritis, Necrosis, Septicemia, Convulsions, Erysipelas, Peritonitis, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

L 67889

REGISTERED NO.

159 D 67889

CITY OF BALTIMORE: (No. Municipal Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Oliver(a) RESIDENCE NO. 504 W. Redwood St

(Usual place of abode)

ST., 4 WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

62

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER

John Oliver11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER

Margt Laughlin13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14

Informant
(Address)Hospital RecordsMunicipal Hospital

15

Filed

19

ROBERT R. KRAVITZ

Registrar

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 19 19 22, to Sept. 22 19 22,that I last saw him alive on Sept. 22 19 22,and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration)

1 yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Dr. W. H. H. H.

M. D.

7/21/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURNING, CREMATION OR REMOVAL
UNIVERSITY OF MARYLAND

DATE OF BURIAL

Sept 27 19 22

20 UNDERTAKER

Commissioner Health

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67890

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital) ST. 76 WARD

2-FULL NAME

Frank Zulker

(a) RESIDENCE NO.

Unknown

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1851

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Philadelphia

Pennsylvania

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hospital Records

Municipal Hospital

15

Filed

SEP 27 1922

ROBERT R. KRAUTER

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 8, 19 22, to Sept. 22, 19 22, that I last saw him alive on September 21, 19 22, and that death occurred, on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde M. Buehl M. D.

9/26/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.

20 UNDERTAKER

Commissioner Health,

ADDRESS

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67891

CERTIFICATE OF DEATH.

D 67891

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2215 N. Calvert* ST.; *12* WARD)

2-FULL NAME

Matthew K. Aiken, Jr

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

2215 N. Calvert

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

*Oct. 16, 1870*7 AGE *51* Years *11* Months *9* Days.If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Book-keeper*(b) General nature of industry,
business, or establishment in
which employed (or employer)*Pharm. Jeweler*

(c) Name of employer

*E. J. Sadler Son*9 BIRTHPLACE (city or town)
(State or country)*Baltimore*

10 NAME OF FATHER

Matthew K. Aiken

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Carroll Co.

12 MAIDEN NAME OF MOTHER

Mary Virginia Jerome

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore

14

Informant

(Address)

Edith M. Aiken
2215 N. Calvert St.

15

Filed

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 25, 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Sept. 28, 1920, to Sept. 25, 1922,*that I last saw him alive on *Sept. 24, 1922,*and that death occurred, on the date stated above, at *1 p.* m.

The CAUSE OF DEATH* was as follows:

Angina pectoris(duration) *2* yrs. — mos. — ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of —Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *C. D. Greenkew*, M. D.19 (Address) *3949 Greenmount Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Catholic at Sept 28, 1922

20 UNDERTAKER

ADDRESS

E. A. Kiedupf *501 E 22*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67892

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Lombard & Greene.

ST.

WARD)

2-FULL NAME

Charles Marian Smith

(a) RESIDENCE. NO.

Hanover, Md.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

4

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,

or Divorced (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Georgia Smith

6 DATE OF BIRTH (month, day, and year)

Sept 16 1846

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

76 years.

0

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Hanover, Md.

(State or country)

10 NAME OF FATHER

Josephus Smith

11 BIRTHPLACE OF FATHER (city or town)

Hanover, Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Georgia Phelps

13 BIRTHPLACE OF MOTHER (city or town)

Hanover, Md.

(State or country)

14

Informant

(Address)

Chas M. Smith Jr

Hanover Md

15

Filed

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/25

1922

17

I HEREBY CERTIFY, That I attended deceased from

8/21

1922, to

9/25

1922

that I last saw him alive on

9/25

1922

and that death occurred, on the date stated above, at

10:50 P. m.

The CAUSE OF DEATH* was as follows:

diffuse Broncho Pneumonia

(duration)

yrs.

mos.

2 ds.

CONTRIBUTORY

(Secondary)

Chronic Benign Prostate

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

yes

Date of

Sept 16 1922

Was there an autopsy?

no

What test confirmed diagnosis?

Physical signs +

Clinical, Test 3 Jones

(Signed)

M. D.

19

Address

Stoney Run Md

*State the Disease Causing Death, or in death from violent cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Stoney Run Md

Sept 28 1922

20 UNDERTAKER

ADDRESS

Wm J Tickener & Sons

Hr Pa

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67893

CERTIFICATE OF DEATH.

100-001
D 67893
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 2 WARD)2-FULL NAME John Rudzynski(a) RESIDENCE No. 837 S. Bond St. ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18637 AGE Years 59 Months -- Days -- If LESS than 1 day, hrs. -- or min. --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland10 NAME OF FATHER Martin Rudzynski11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland14 Informant Hospital Records,(Address) Municipal Hospital,15 Filed 27 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 25 19 2217 I HEREBY CERTIFY, That I attended deceased from Sept 19, 19 22, to Sept. 25, 19 22.that I last saw him alive on Sept. 25, 19 22.and that death occurred, on the date stated above, at 1:05 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia(duration) 3 yrs. mos. ds.CONTRIBUTORY Chronic alcoholism(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? yesWhat test confirmed diagnosis? Autopsy(Signed) Dr. M. D.9/26/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy-Rosary Cem. DATE OF BURIAL Sept 28. 1922.20 UNDERTAKER M. F. Sadowski, ADDRESS 405 S. Ann St.CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

D 67894

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67894

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *100 N. Kenwood Ave* ST., *6* WARD)

2-FULL NAME

Frederick J. Baier

(a) RESIDENCE NO.

100 N. Kenwood Ave ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred *46* yrs. *0* mos. *5* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*May M. Baier*

6 DATE OF BIRTH (month, day, and year)

Sept. 20-1876

7 AGE

46

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

063

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md.*

10 NAME OF FATHER

*Andrew Baier*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Margaret Bugelman*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Germany*

14

Informant
(Address)*May M. Baier
1401 N. Kenwood Ave.*

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 25 1922*17 I HEREBY CERTIFY, that I attended deceased from *June 10*, 1922, to *Sept 25*, 1922.
that I last saw him alive on *Sept 24*, 1922,
and that death occurred, on the date stated above, at *7.20 A. m.*

The CAUSE OF DEATH* was as follows:

*Cronic (Valvular) Cardiac Dis.*CONTRIBUTORY (Secondary) *Cerebral - Embolism*
(duration) *2* yrs. *—* mos. *—* ds.
(duration) *3* yrs. *—* mos. *3* ds.18 Where was disease contracted
if not at place of death? *✓*Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*What test confirmed diagnosis? *Usual*(Signed) *Thos. B. Brown*, M. D.19 (Address) *1250 Broadway*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer Cem

20 UNDERTAKER

Lilly & Zeiler

DATE OF BURIAL

Sept. 28 1922

ADDRESS

403 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67895

D 67895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Joseph's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. WARD)

2-FULL NAME

Walburga Bitzelberger

(a) RESIDENCE NO.

3208 Foster Ave.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed,

or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Matthew Bitzelberger

6 DATE OF BIRTH (month, day, and year)

July 28-1882

7 AGE

Years

Months

Days

If LESS than

40

1

30

1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md.

10 NAME OF FATHER

Matthew Lindner

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna M. Krause

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)Matthew Bitzelberger
3208 Foster Ave.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 17, 1922, to Sept. 27, 1922.

that I last saw her alive on Sept. 27, 1922,

and that death occurred, on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Pregnancy.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

P.S. & S

(Signed) John J. Krager, M. D.

19 (Address) 2627 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Sacred Heart Cem.

DATE OF BURIAL

Sept 30 1922

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

4038 7th Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 D 67896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 W. Fairmount St. WARD 70)

2-FULL NAME

Henry Ernest Dunsing

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1826 W. Fairmount St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mary A. Dunsing6 DATE OF BIRTH (month, day, and year) Sept. 11 - 18607 AGE Years Months Days If LESS than 1 day, hrs. or min.
62 - - 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butcher. 013

(b) General nature of industry, business, or establishment in which employed (or employer)

Pork Packer.

(c) Name of employer

Jacob C. Schaeffer Co.

9 BIRTHPLACE (city or town) (State or country)

Bremen Germany.

10 NAME OF FATHER

Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Mrs. Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany.

PARENTS

14 Informant Lena Dunsing
(Address) 1826 W. Fairmount St.15 Robert P. Harrison

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27th 1922

17

I HEREBY CERTIFY, That I attended deceased from June, 1922, to Sept 26th, 1922, that I last saw him alive on Sept 26th, 1922,and that death occurred, on the date stated above, at 4:30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Intestinal).(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes, Date of Aug 16th 1922Was there an autopsy? NoWhat test confirmed diagnosis? Clinical & Empirical(Signed) John H. Hoff, M. D., 19 (Address) 1843 W. 13th St. Bt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Louison Park Sept. 29, 1922

20 UNDERTAKER

ADDRESS

MM Coors, 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67897

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *James H. 1* St., *3* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

(Residence in Baltimore: No. *1415 Eastman Ave* St.; yrs., *55* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

*White*1-Single,
2-Married,
3-Widowed,
or 4-Divorced.
(Write the word.)

6-DATE OF BIRTH.

*March**12**1867*

(Month)

(Day)

(Year)

7-AGE.

55

yrs.

6

mos.

15

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....*Laborer*

9-BIRTHPLACE.

(State or Country).

Balto Md

10-NAME OF FATHER.

James Ryan

11-BIRTHPLACE OF FATHER.

(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER.

Margaret Clifford

13-BIRTHPLACE OF MOTHER.

(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

John H. Ryan (Brother)

(Address)

1715 Wilkes Ave

15-

Robert P. Harrison,

Filed

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Sept**26**1922*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cerulean PT Pericarditis
Regimen due to Fractured
Skull from fall on pavement
Sept 22/22 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *J. S. H. Patton* (Coroner.) M. D.9-27-1922 (Address) *108 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

*New Cathedral**Sept 28*

1922

20-UNDERTAKER.

ADDRESS

*Wm Cook**502 E North*

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67898

CERTIFICATE OF DEATH.

129 D 67898

1-PLACE OF DEATH

CITY OF BALTIMORE: (No

Jackson St. Curtis Heights WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

August H. Jackson

(a) RESIDENCE NO.

Curtis Heights

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

6 If married, widowed, or divorced

(or) HUSBAND of (or) WIFE of

Mary C. Jackson

6 DATE OF BIRTH (month, day, and year)

April 15, 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

5

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labourer

(b) General nature of industry, business, or establishment in which employed (or employer)

040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Isaac Jackson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Snow Hill Md

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

E. Barnes 1526 Bay St

15

Filed

Robert P. Harrison, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 28, 1922, to Sep 20, 1922.

that I last saw h. alive on Sep 20, 1922.

and that death occurred, on the date stated above, at 9:40 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chas. O. Brock

M. D.

(Address)

1-5 3rd St. North Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

Cedar Hill

Sept 28 1922

20 UNDERTAKER

ADDRESS

Wm Cook

502 E. North

Exact statement of ONCE-A-TION is very important. See instructions on back of certificates.

D 67899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67899

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Md. General Hospital* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Jones*(a) RESIDENCE NO. *Rising Sun, Md.* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of 6 DATE OF BIRTH (month, day, and year) *Sept 26, 1922*7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*(b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer 9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *Arthur A Jones*11 BIRTHPLACE OF FATHER (city or town) *Maryland* (State or country) 12 MAIDEN NAME OF MOTHER *Clara Watson*13 BIRTHPLACE OF MOTHER (city or town) *Pennsylvania* (State or country) 14 Informant *Clara Jones (mother)* (Address) *Rising Sun, Md.*15 Filed *Robert P. Heston* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 26 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept 26*, 1922, to *Sept 26*, 1922, that I last saw him alive on *Sept 26*, 1922, and that death occurred, on the date stated above, at *4:30 A.M.*

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *None*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Did an operation precede death? *no* Date of Was there an autopsy? *no*What test confirmed diagnosis? (Signed) *John A. Thompson*, M. D., 19 (address) *115 Gladstone*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *Rising Sun, Md.*DATE OF BURIAL *Sept 7, 1922*20 UNDERTAKER *Wm. Beach*ADDRESS *505 E. North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

71522

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67900

CERTIFICATE OF DEATH.

46 D 67900

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Alden(a) RESIDENCE No. 3917 Hardman Ave.ST. 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

9 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Walter Alden Unknown
1883

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
39 -- -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Connecticut10 NAME OF FATHER Chas. Gooden11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.12 MAIDEN NAME OF MOTHER Mary McClasky13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

PARENTS

14 Informant Hospital Records,
(Address) Municipal Hospital15 Robert F. Harrison,

Filed

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1922, to Sept. 26, 1922, that I last saw her alive on Sept. 25, 1922, and that death occurred, on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:Cerebral Hemorrhage
(duration) 6 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

Metatars to diaphysis
(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde McNeill M. D.19 PLACE OF BURIAL, CREMATION OR RE-
MORAL St. Michael's Cemetery Bridgetown
Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MORAL St. Michael's Cemetery Bridgetown
Address Municipal Hospital

20 UNDERTAKER

George F. Ruth 1735 Hayford Ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

67901

HEALTH DEPARTMENT—CITY OF BALTIMORE

67901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *830 So. Milton Ave*
City of BALTIMORE: (No. *6* St. *6* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Alfred Basco*
(Residence in Baltimore: No. *1623 E. Fayette St.* St. *2* yrs. *0* mos. *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *colored* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*
6-DATE OF BIRTH *unknown* (Month) (Day) (Year)
7-AGE *45* yrs. *0* mos. *0* ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer) *040*
9-BIRTHPLACE (State or Country) *Virginia*
10-NAME OF FATHER *James Basco*
11-BIRTHPLACE OF FATHER (State or Country) *Va.*
12-MAIDEN NAME OF MOTHER *Angela Jackson*
13-BIRTHPLACE OF MOTHER (State or Country) *Va.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Edith Basco*
(Address) *1623 E. Fayette*

15-
Filed *Robert P. Harrison,* Registrar.
27 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Sept 25th* 19*22*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* find that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Paralysis of heart
Died at once
CONTRIBUTORY (Secondary) *None*
(Signed) *Thos B. Forton* M. D.
Sept 24 1922 (Address) *Curtis Bay*
*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) Nature of Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death *0* yrs. *0* mos. *0* ds. In the State *0* yrs. *0* mos. *0* ds.
Where was disease contracted, if not at place of death?

Former or usual residence
19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
St. Auburn Ch. *Sept 28 1922*
20-UNDERTAKER ADDRESS *114 W. Brown's Island Sch.*

D 67902

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67902

1-PLACE OF DEATH *San Francisco, Cal.*City of BALTIMORE: No. *San Francisco, Cal.* St. *11* Ward)2-FULL NAME *Granville Christopher Freeman*(Residence in Baltimore: No. *No residence in this city* St.; yrs. *none* mos. *none* ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, (Write the word.) *married*6-DATE OF BIRTH, *about* 1868 (Month) (Day) (Year)7-AGE, *54* yrs. *none* mos. *none* ds. If LESS than 1 day, *886* hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Secretary to U.S. Congressman* (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Yolo Co., California*PARENTS. 10-NAME OF FATHER, *Wm. Freeman* 11-BIRTHPLACE OF FATHER, (State or Country), *Calif.* 12-MAIDEN NAME OF MOTHER, *Wm. Freeman* 13-BIRTHPLACE OF MOTHER, (State or Country), *Calif.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. W. Meas & Son*(Address) *805 N. Calvert St.*15- *Robert P. Harrison*Filed *1922* 192

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept. 22* 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull (Duration) *about 1/2 hr.* yrs. *none* mos. *none* ds. *none*CONTRIBUTORY *automobile accident* (Secondary) (Duration) *none* yrs. *none* mos. *none* ds. *none*(Signed) *J. T. Freeman* M. D. (Coroner.) *Sept. 24* 1922 (Address) *2802 Edmondson Ave.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death *none* yrs. *none* mos. *none* ds. In the State *none* yrs. *none* mos. *none* ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *San Francisco, Cal.* DATE OF BURIAL, *Sept. 27* 192220-UNDERTAKER, *Henry W. Meas & Son* ADDRESS *805 N. Calvert St.*

CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Via Penn. R.R. Escort, Mrs. Louise Hillman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67903 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Union Protestant Infirmary

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry H. Meyers

(Residence in Baltimore: No. *****

St.; yrs., mos. / ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Sept. 21st, 1890 (Month) (Day) (Year)

7-AGE,

31

9

4

IF LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...

Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)...

Western Md. R.R.

9-BIRTHPLACE,

(State or Country), Illinois

10-NAME OF FATHER,

Henry Meyers

11-BIRTHPLACE OF FATHER

(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary Vogel

13-BIRTHPLACE OF MOTHER

(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Lottie Meyer

(Informant)

215 Frederick St.

(Address)

15-

Hanover, Pa.

Robert P. Harrison,

Filed

191

Marial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 26th, 1912 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry.

find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental death of Cep.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

R. R. accident

(Duration) yrs. mos. ds.

(Signed) J. T. Harrison, M. D.

(Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. / ds. State yrs. mos. / ds.

Where was disease contracted, if not at place of death?

Former or usual residence Hanover, Pa.

19-PLACE OF BURIAL, OR REMOVAL,

Hanover, Pa.

DATE OF BURIAL,

Sept 27, 1912

20-UNDERTAKER

Chas. F. Evans & Son

ADDRESS

118 N. Mt. Royal

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67904

D 67904

CERTIFICATE OF DEATH.

REGISTERED NO. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Unrecorded ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Tomlinson(a) RESIDENCE. No. 1401 Division ST., 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7 19217 AGE Years Months Days If LESS than 1 day, hrs. or min. 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant St Vincent Inf Center (Address) 1401 Division St15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 24 192217 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1922, to Sept 24, 1922, that I last saw him alive on Sept 24, 1922, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Elio-colic(duration) yrs. 2 1/2 mos. ds.

CONTRIBUTORY (Secondary)

Malnutrition(duration) yrs. mos. 2 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical history(Signed) John F. Friedman, M. D.19 (Address) University of Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Upper Marlboro Md Sept 28 1922

UNDERTAKER ADDRESS

Mattie Hughes 1827 W North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

71922

Burial Permit Clerk.

D 67905 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *143* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Sallie Reynolds*(a) RESIDENCE, NO. *Ellicott City, Maryland* WARD. *Ellicott City*

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

*Marshall Reynolds*6 DATE OF BIRTH (month, day, and year) *London 1893*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

William Rhodes

11 BIRTHPLACE OF FATHER (city or town)

Maryland

(State or country)

12 MAIDEN NAME OF MOTHER

Sallie Rhodes

13 BIRTHPLACE OF MOTHER (city or town)

Maryland

(State or country)

14

Informant (Address)

Marshall Reynolds

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *9-26-1922*

17

I HEREBY CERTIFY, That I attended deceased from *9-22-1922*, to *9-26-1922*,that I last saw her alive on *9-26-22*, 19and that death occurred, on the date stated above, at *11:30 A.M.*

The CAUSE OF DEATH* was as follows:

Ectopic Pregnancy
Acute Peritonitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Ischaemic - Cordy's Virus

(duration)

yrs.

mos.

3 ds.

18 Where was disease contracted if not at place of death?

*address above*Did an operation precede death? *yes*Date of *9-24-22*Was there an autopsy? *no*

What test confirmed diagnosis?

Clinical Findings

(Signed)

L.B. Jones

M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in death from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Star

20 UNDERTAKER

Easton Bros

DATE OF BURIAL

Sept 27 1922

ADDRESS

Ellicott

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

271922

Burial Permit Clerk.

D 67906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *722 E. 23rd* ST., *9* WARD)

2-FULL NAME

(a) RESIDENCE NO. *722 E. 23rd St* ST., *9* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April-22-1922*

7 AGE

Years

Months

Days

If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *City*10 NAME OF FATHER *Reuben Wisthoff*11 BIRTHPLACE OF FATHER (city or town) (State or country) *City*12 MAIDEN NAME OF MOTHER *Mary B Wisthoff*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *City*

14

Informant (Address) *Mary B Wisthoff*

15

Filed

Robert P. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *9/26* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

8/1-8, 19 *22*, to *9/26*, 19 *22*.that I last saw her alive on *9/26*, 19 *22*.and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH* was as follows:

*7 days continuous fever**colitis*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Heart failure & Colitis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Specimen & report*(Signed) *J. A. [illegible]*, M. D.9/27, 1922 (Address) *1623 E North Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Episcopal Cem

DATE OF BURIAL

Sept 27 1922

20 UNDERTAKER

Thos. [illegible] Sons

ADDRESS

North Ave

Burial Permit Clerk.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(William Marritt)
D 67907 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67907

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *4X* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mr. Marritt*

(Residence in Baltimore: No. *S.S. H. M. August* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-Single, Married, Widowed, or Divorced. *Married*
(Write the word.)

6-DATE OF BIRTH. *Don't know*
(Month) (Day) (Year)

7-AGE. *25* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Seaman*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country). *England*

10-NAME OF FATHER. *Unknown*

11-BIRTHPLACE OF FATHER.
(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Capt. E. W. Valley*

(Address) *S.S. H. M. August*

15- *Robert P. Harrison,*

Filed 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Sept 27* 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* and that said deceased came to *his* death (by injury.) on the day stated above.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) *Don't know* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Don't know*

(Duration) yrs. mos. ds.

(Signed) *H. H. Gurnea* M. D.
(Coroner.)

9.27. 1922 (Address) *117 W. Saratoga*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Cedar Hill Cem. Sept 28 1922

20-UNDERTAKER. ADDRESS

Joseph B. Cook 1003 W. Baltus

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 67908****D 67908**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S. Decker ave. 1 WARD)

2-FULL NAME

Rose E. Koerner

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

311 S. Decker ave. 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Charles Koerner

6 DATE OF BIRTH (month, day, and year)

Nov. 8th 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

29 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Adam Sliffer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

City

12 MAIDEN NAME OF MOTHER

Veronica Jubb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

City

14

Informant (Address)

Charles Koerner
311 S. Decker ave.

15

Filed

Robert F. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 25 Sep 1922

17

I HEREBY CERTIFY, That I attended deceased from

21 Sep 1922 to 25 Sep 1922that I last saw him alive on 25 Sep 1922and that death occurred, on the date stated above, at 12:35 p.m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Carbuncle of right neck

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of 23 Sep

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. M. D. M. D.19 (Address) 301 S. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak Lawn Cemetery 9/28 1922

20 UNDERTAKER

J. A. Moran E. Ball

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67909 HEALTH DEPARTMENT—CITY OF BALTIMORE 67909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

St.

Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.

yr.

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE.

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH.

(Month)

(Day)

(Year)

7-AGE.

yr.

mos.

ds.

IF LESS than 1 day,

hrs.

or,

min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

PARENTS

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

SEP 28 1922

ROBERT A. KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, au-

topsy or inquiry.) find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Failure - caused by
collapse of coronary artery
sufficiently traced
about 4 days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

(Coroner)

1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent causes, state (1) Means of Injury; and (2) whether Accidental, suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

D 67910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001

D 67910

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph Scott

(a) RESIDENCE. NO.

335 Hillen Rd. St.

WARD.

Towson, Md.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

26

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro-

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Sophie Scott

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

52.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Towson
Maryland

10 NAME OF FATHER

Nathaniel Scott

11 BIRTHPLACE OF FATHER (city or town)

Maryland

(State or country)

12 MAIDEN NAME OF MOTHER

Rosie Miller

13 BIRTHPLACE OF MOTHER (city or town)

Maryland

(State or country)

PARENTS

14 Informant

(Address)

15

SEP 28 1922

ROBERT A. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 25 1922

17

I HEREBY CERTIFY, That I attended deceased from

*August 29, 1922, to Sept. 25, 1922,*that I last saw him alive on *Sept 25, 1922*and that death occurred, on the date stated above, at *9:45 P. m.*

The CAUSE OF DEATH* was as follows:

*Acute Suppurative Otitis Media*CONTRIBUTORY (duration) yrs. mos. *3* ds.*Bilateral broncho-pneumonia*(Secondary) (duration) yrs. mos. *1* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

Clinical history(Signed) *Anthony V. Bachner* M. D.(Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Burial Hill Cem. Sept 28 1922

20 UNDERTAKER

*Samuel Hensley**578*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 N. Hollough ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jacob Harris(Residence in Baltimore: No. 1428 N. Hollough St.; 18 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male4-COLOR OR RACE, Colored5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, December, 1880

(Month)

(Day)

(Year)

7-AGE, 42 yrs., mos. ds.

If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer)...9-BIRTHPLACE, (State or Country), Essex Co Va.10-NAME OF FATHER, Clarence Harris11-BIRTHPLACE OF FATHER (State or Country), Essex Co Va.12-MAIDEN NAME OF MOTHER Virginelle Harris13-BIRTHPLACE OF MOTHER (State or Country), Essex Co Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginelle Harris(Address) 1428 N. Hollough St.

15-

Filed SEP 28 1922

191

ROBERT R. KRAUTER,

Bureau of Vital Statistics, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 26th, 1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from June 22nd, 1922, to Sept 25th, 1922.that I saw him alive on Sept 22nd, 1922 and that death occurred, on the date stated above, at 5:00 m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis
Exhaustion
Gradual
Sept 26th, 1922 (Address) 607 N. Charles St.

CONTRIBUTORY (Secondary)

(Signed) W. H. H. H. M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL, Sept 29, 1922

20-UNDERTAKER

ADDRESS 578

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67912

D 67912

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

(Address).

15-

Filed

SEP 28 1922

191. ROBERT R. KRAUTER,

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67913

CERTIFICATE OF DEATH.

D 67913

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1300 Division*ST. *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harriet Johnson(a) RESIDENCE. NO. *1300 Division*
(Usual place of abode)ST. *17* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *colored* 5 Single, Married, Widowed, or Divorced (write the word) *married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Chas. H. Johnson*6 DATE OF BIRTH (month, day, and year) *Oct. 11-1873*7 AGE Years *49* Months *11* Days *15* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa.

10 NAME OF FATHER

Isaiah Shaw

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Julianne Raven

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

*Rachel Fairfax
1300 Division St.*

15

Date

*SEP 28 1922*ROBERT R. KRAUTER
Registrar

Burial Permit No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 26 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*sep. 24 1922 to sep. 26 1922*that I last saw him alive on *sep. 26 1922*and that death occurred, on the date stated above, at *5:30 a. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Atherosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edw. J. Wheaton* M. D.Address *1230 Grand Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Laurel Cemetery**Sept 29 1922*

20 UNDERTAKER

ADDRESS

*Jno. M. Johnson**1234
City St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15863 67914

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL ST. 195 WARD)
CITY OF BALTIMORE: (NO. 11)

2-FULL NAME

2-FULL NAME James S. Winans

(a) RESIDENCE NO. 56 Annapolis Ave. Nt. ST. Winans WARD (II non

(a) RESIDENCE No. 16 Annandale (Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
-------	-----------------	--

5a If married, widowed, or divorced
HUSBAND of
 (or) WIFE of Richard & Posie Simmons. (Parents)

6 DATE OF BIRTH (month, day, and year) July 8, 1922

7 AGE 2 Years 19 Months 0 Days
1 day, 0 hr
or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry,
business, or establishment in
which employed (or employer).....

(c) **Name of employer**

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland

10 NAME OF FATHER *Richard Simmons*

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER *Rosie Thomas*

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant **JOHNS HOPKINS HOSPITAL.**
(Address) *Records*

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1922

17 I HEREBY CERTIFY, That I attended deceased from
Sept 25, 1920, to Sept 27, 1922.

that I last saw him live on Sept 27, 1972

and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:
Diarrhoea (not dysentery)

(duration) _____ yrs. / 1 mos _____ ds.

CONTRIBUTORY (Secondary) *Malnutrition*

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis

(Signed) Horton Caspares, M. D.

19 (Address) Johns Hopkins Hospital

19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
-----------------------------------	----------------

19 PLACE OF BURIAL, CREMATION OR REMOVAL.

MOVAL *Laurel* ADDRESS *Laurel*

20 UNDERTAKER

John W Henderson

D 67915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 67915

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 25 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Hugh L. Dryden

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Pocomoke City Md.

12 MAIDEN NAME OF MOTHER

Mary L. Travis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant (Address)

Hugh L. Dryden 2110 E Biddle St

15

Filed

, 19

ROBERT R. KRAUTER, Registrar

Bureau of Health Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept 11 19 22 to Sept 26 19 22 that I last saw her alive on Sept 26 19 22 and that death occurred, on the date stated above, at 5. 17 p.m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Broncho Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

not known

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed) George E. Shannon, M. D.

, 19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn Cemetery

Sept 29 1922

20 UNDERTAKER

ADDRESS

H. Vander & Sons

1710 Flat St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67916

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4016 Edmondson Ave. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William B. Landin

(a) RESIDENCE. NO.

4016 Edmondson Ave. ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Esther C. Landin

6 DATE OF BIRTH (month, day, and year)

Mar 7, 1859

7 AGE

63

6

20

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Perryville Md

10 NAME OF FATHER

William J. Landin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Perryville Md

12 MAIDEN NAME OF MOTHER

Laura V. Gist

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

H. Gist Landin 4016 Edmondson Ave

15

SEP 26 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

August 31, 1921, to Sept 27, 1922

that I last saw him alive on Sept 27, 1922

and that death occurred, on the date stated above, at 4-30 p.m.

The CAUSE OF DEATH* was as follows:

Atherosclerosis

CONTRIBUTORY

(Secondary)

Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank N. Billis M. D.

19 (Address) 2838 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

9-29 1922

20 UNDERTAKER

ADDRESS

Neway & Jenkins Home Co

M. D. Lullo

D 67917 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67917

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3415 Falls Road ST., 13 WARD)

2-FULL NAME

Annie B. Blessing

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

3415 Falls Road

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. - mos. - ds. How long in U. S., if of foreign birth? 2 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Frank J. Blessing

6 DATE OF BIRTH (month, day, and year)

February 26 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46

7

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md

10 NAME OF FATHER

Frank Brashears

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town)

Not Known

(State or country)

14

Informant

(Address)

Mr. Frank J. Blessing

3415 Falls Road

15

Informant

(Address)

DR. J. J. WINTER, JR.

SEP 28 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 2 1922 to Sept. 27 1922

that I last saw him alive on Sept. 26 1922

and that death occurred, on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

OVER

Acute Insufficiency,

CONTRIBUTORY Cerebral Pressure.

(duration) yrs. mos. 2 ds.

(Secondary) (duration) yrs. 9 mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Spinal fluid

(Signed) C. J. Winters, M. D.

(Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOYAL Holy Redeemer Cemetery

DATE OF BURIAL Sept. 30 1922

20 UNDERTAKER Henry Wood (Son) 1501 E. Bay St.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired. 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

High Blood pressure
Chronic nephritis.
Terminal cerebral
hemorrhage.

D 67918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

111-902
D 67918

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Newton Swatzbaugh(a) RESIDENCE, NO. 856 W. 37th

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMelva Swatzbaugh

6 DATE OF BIRTH (month, day, and year)

Feb. 10/1875

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

47717

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Auto mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

self9 BIRTHPLACE (city or town)
(State or country)Maryland

10 NAME OF FATHER

Edward Swatzbaugh

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Collette (?)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

Melva Swatzbaugh

(Address)

856 W 37th St

15

Filed

19

SEP 28 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 26, 1922, to Sept. 27, 1922,that I last saw him alive on Sept. 27, 1922,and that death occurred, on the date stated above, at 130 A.M.

The CAUSE OF DEATH* was as follows:

Perforated duodenal ulcerCONTRIBUTORY
(Secondary)(duration) yrs. mos. 3 ds.Diffuse peritonitis(duration) yrs. mos. 3 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? Yes Date of 9/26/22Was there an autopsy? noWhat test confirmed diagnosis? Operation(Signed) Anthony V. Buchner, M. D.19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Armid RidgeSept 29 1922

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut

D 67919

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Morrow Hospital* ST., *16* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

121 Pine St., Philadelphia ST.,

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Merchant & Haman**Merchant Marine*

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Informant (Address)

*SEP 28 1922**ROBERT E. KAUFER,*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 27 1922*

17

I HEREBY CERTIFY, That I attended deceased from *5/24*, 1922, to *9/27*, 1922.that I last saw him alive on *9/27*, 1922.and that death occurred, on the date stated above, at *1 a* m.

The CAUSE OF DEATH* was as follows:

*Permeous Anemia*CONTRIBUTORY (Secondary) (duration) yrs. *9* mos. ds. *Scarhea*18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*What test confirmed diagnosis? *Microscopic*(Signed) *P. E. Schenck*, M. D.*9/27 1922* (Address) *Morrow Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Trinity Cemetery

20 UNDERTAKER

J. L. Linsan & Bro E. Balto St

DATE OF BURIAL

Sept 28 1922

ADDRESS

1127

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67920

CERTIFICATE OF DEATH.

31 D 67920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

339-West-21st

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

June Marie Allen

(a) RESIDENCE. NO.

339-West-21st

ST.:

WARD.

Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

0 yrs. 5 mos. 4

ds. How long in U. S., if of foreign birth?

0 yrs. 5 mos. 24

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

April-24-1922

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

0

5

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town)

Baltimore

(State or country)

Maryland

10 NAME OF FATHER

Van B. Allen

11 BIRTHPLACE OF FATHER (city or town)

Floyd Co.

(State or country)

Georgia

12 MAIDEN NAME OF MOTHER

Lula F. Weaver

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Maryland

14

Informant

(Address)

Van Ballen - (father)

339-W-21-St. City

15

Date

SEP 28 1922

ROBERT R. MAUTER,

Bureau of Health Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 28 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 27, 1922, to, 1922,

that I last saw her alive on Sept. 27, 1922,

and that death occurred, on the date stated above, at 6:35 a. m.

The CAUSE OF DEATH* was as follows:

Inanition -
Tubercular (?)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Tuberculosis (probable)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Don't know

Did an operation precede death?

Date of

Was there an autopsy?

No.

What test confirmed diagnosis?

No.

(Signed)

Hugh Forsythe, M. D.

, 19 (Address)

424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Parklawn - Baltimore, Md. Sept 29 1922

20 UNDERTAKER

ADDRESS

STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

108 W. NORTH AVE

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

HEALTH DEPARTMENT—CITY OF BALTIMORE
D 67921

CERTIFICATE OF DEATH.

67921

1-PLACE OF DEATH 2 Belmont Road Baeto md

REGISTERED NO.

CITY OF BALTIMORE: (No. 2 Belmont Rd ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Stevens

(a) RESIDENCE NO. 2 Belmont Road ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day 6 hrs. or min.

16 hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

SEP 28 1922

ROBERT A. BAUTER,

Bachel Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 25, 1922, to Sept 26, 1922, that I last saw him alive on Sept 26, 1922, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth about 6 month retro gestation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) C. D. Macdonald M. D.

(Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health

SEP 28 1922

D 67922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

1900 Boone St ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louisa F. Lamery

(a) RESIDENCE. No.

1900 Boone St ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

1840

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

Richard Bonpland

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

England

14

Informant

(Address)

Mrs W. E. Gorges
1900 Boone St

15

Filed

Sept. 19. 2. Harriett

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 26th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1919, to Sept 25th 1922,that I last saw him alive on Sept 25th 1922,

and that death occurred, on the date stated above, at 3:58 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 18 ds.

CONTRIBUTORY
(Secondary)

Pulmonary Edema

(duration) yrs. mos. 4 hrs. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Michael D. Adams, M. D.

, 19 (Address) 2360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem

Sept 29 1922

20 UNDERTAKER

ADDRESS

Martin J. Hagedorn 1827 W North

87922

Serial Form 12-21-22.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67923

CERTIFICATE OF DEATH.

D 67923

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 148 Irving ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Marie Eschale Ching(a) RESIDENCE. NO. 148 Irving St. ST. 70 WARD.(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of —6 DATE OF BIRTH (month, day, and year) July 4. 227 AGE Years 2 Months 24 Days — If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) Balt
(State or country)10 NAME OF FATHER Joseph Ching11 BIRTHPLACE OF FATHER (city or town) Lebanon Md
(State or country)12 MAIDEN NAME OF MOTHER Mary Warthen13 BIRTHPLACE OF MOTHER (city or town) Lebanon Md
(State or country)14 Informant Joseph Ching
(Address) 148 Irving St.15 Filed Robert P. Harrison RegistrarBurial Permit —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 192217 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1922, to Sept 28, 1922, that I last saw him alive on Sept 27, 1922, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute Below Pneumonia(duration) yrs. mos. 5 ds.CONTRIBUTORY Conjunctal Weakness
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? —(Signed) Howard Jones, M. D.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross Harp. R. Sept 29 1922

20 UNDERTAKER ADDRESS

Wm Cook 502 E. N. Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

15-826
D 67924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67924

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: JOHNS HOPKINS HOSPITAL ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Joseph Kapovitz

(a) RESIDENCE NO.

1232 S. Decker City

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

16 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

~~WIFE of~~Anastasia Kapovitz

6 DATE OF BIRTH (month, day, and year)

Oct 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Austria

10 NAME OF FATHER

John Kapovitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Austria

12 MAIDEN NAME OF MOTHER

Anna Palitska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

JOHNS HOPKINS HOSPITAL

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 26 1922, to Sept 27 1922,that I last saw him alive on Sept 27 1922,and that death occurred, on the date stated above, at 9:00 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) 2 yrs. 2 mos. — ds.

CONTRIBUTORY

(Secondary)

Chronic Emphysema & BronchitisCardiac Hypertrophy 5 yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. R. Bugg M. D.Sept 27 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

St. Stanislaus

DATE OF BURIAL

Sept 30 1922

20 UNDERTAKER

M. F. Sadowski

ADDRESS

405 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

WILLIAM WAGNER

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67925

D 67925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Spalding Ave. ST. 27 WARD)

2-FULL NAME

(Residence in Baltimore: No. 411 Spalding Ave. St. 57 yrs. 5 mos. 24 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Widower

6-DATE OF BIRTH,

April 13, 1864
(Month) (Day) (Year)

7-AGE,

58 yrs. 5 mos. 24 ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

File Clerk, Vocational Board

9-BIRTHPLACE,
(State or Country).

York, Pa.

10-NAME OF FATHER,

Henry Wagner

11-BIRTHPLACE OF FATHER
(State or Country).

Germany

12-MAIDEN NAME OF MOTHER

Katherine Fritz

13-BIRTHPLACE OF MOTHER
(State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Margaret C. Little

(Address)

7 Cold Spring Ave.

15-

Robert P. Harrison,

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

September 27, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

June 15, 1923, to September 27, 1923,
that saw him alive on September 21, 1923,

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach with
metastases

(Duration) 1 yrs. 8 mos. 12 ds.

CONTRIBUTORY

(Secondary)

Myocarditis (Duration) 3 yrs. 8 mos. 12 ds.

(Signed) J. W. Marshall, M. D.

Sept 27, 1923. (Address) 3 E. Pratt St. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Oliver

DATE OF BURIAL,

Oct 30, 1923

20-UNDERTAKER

Horace H. Burgee 363 Falls Rd.

important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67926

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67926

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *2101 E Federal* St., *8* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2101 E Federal* St., *38* yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

Married
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH

Aug 3 1863
(Month) (Day) (Year)

7-AGE

59 yrs., *1* mos., *23* ds.

If LESS than 1 day,

..... hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Retired
000

9-BIRTHPLACE

(State or Country), *Austria*

10-NAME OF FATHER

Edmund Schram

11-BIRTHPLACE OF FATHER

(State or Country), *Austria*

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

11-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marie Hess Daugh

(Address)

2101 E Federal

15-

Robert P. Harrison,

Filed

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 16 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-

topsy or inquiry.) and that said deceased came to *death*
on the day stated above.

The CAUSE OF DEATH was as follows:

Heart Lesion

(Fall dead in bed room)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

John H. Miller

M. D.

(Coroner.)

9-16-22 (Address) *508 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Sept 30 1922

20-UNDEBTAKER

ADDRESS

Wendell Dyffel & Co

378 Wm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 M&T 1500 Hks.

D 67927 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67927

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 750 H. Fayette ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 750 H. Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1831

7 AGE Years 90 Months 11 Days 30 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

10 NAME OF FATHER Henry Hillary

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Regan

13 BIRTHPLACE OF MOTHER (city or town) Don't know (State or country)

14 Informant Robert L. Carn (Address) 750 H. Fayette St.

15 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 20, 1922, to Sept 26, 1922,

that I last saw her alive on Sept 26, 1922,

and that death occurred, on the date stated above, at 11:50 P. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Broncho-Pneumonia (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glazman, M. D.

Sept 27 1922 (Address) 26 P. 7 Chesapeake Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cem.

Sept 29 1922

20 UNDERTAKER

ADDRESS

Wm. H. H. Taylor & Son

801 H. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67928

D 67928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hospital.

REGISTERED NO.

CITY OF BALTIMORE: (No.

Western Ave

ST.,

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Martha Brice or Briscoe

(a) RESIDENCE NO.

117 Welcome Alley

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

19 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Colored

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1903

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

Charles Brice

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Queenie Upsher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Hospital Records

28 1922

Report of Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-26-22

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Sept 26, 1922, that I last saw her alive on Sept 26, 1922, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Laboratory findings

(Signed)

J. Richardson Boyer, M. D.

, 19

(Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Auburn

Sept 27, 1922

20 UNDERTAKER

Daniel Easton

ADDRESS

916 Pa Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 67929

CERTIFICATE OF DEATH.

113 D 67929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 N. Gilman ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Wm. J. Forrest

(a) RESIDENCE. NO.

1012 N. Gilman ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

7

mos.

23

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Leol

5 Single, Married, Widowed, or Divorced (write the word)

Single.

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofX

6 DATE OF BIRTH (month, day, and year)

Feb 5-1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.723

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

John E. Forrest11 BIRTHPLACE OF FATHER (city or town)
(State or country)Washington D.C.

12 MAIDEN NAME OF MOTHER

Pauline Smith13 BIRTHPLACE OF MOTHER (city or town)
(State or country)New York N.Y.

14

Informant
(Address)Joe E. Forrest
1012 N. Gilman

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 28 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 25 19 22 to Sept 28 19 22that I last saw him alive on Sept 27 19 22and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis(duration) yrs. mos. 3 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?XDid an operation precede death? no Date of XWas there an autopsy? noWhat test confirmed diagnosis? Regular(Signed) Dr. E. J. Link M. D.Address 1313 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Paul's ChurchSept 29 19 22

20 UNDERTAKER

ADDRESS

Wm. E. Forrest912

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

28 1922

D 67930

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67930

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 W. Gilman St. WARD 16)

2. FULL NAME

Julius, C. Wiencke

(a) RESIDENCE No.

908 W. Gilman St. WARD A

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs.mos. 5

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Anna, M. Wiencke

6 DATE OF BIRTH (month, day, and year)

Sept 22 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6625

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Isaac Hamburger

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Fredrick Wiencke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Helen Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Anna, M. Wiencke
908 W. Gilman St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 20 1922 to Sept 27 1922.that I last saw him alive on Sept 27 1922and that death occurred, on the date stated above, at 3:30 p m.

The CAUSE OF DEATH* was as follows:

Soreness of tongue & left pillar
of mouth. Metastatic Soreness of
spinal cord (duration) 7 yrs. 7 mos. 7 ds.

CONTRIBUTORY

(Secondary)

Chronic suppurative (duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

Section of growth on tongue

(Signed)

Wm. Nichol, M. D.Sept 28 1922 (Address) 2901 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western CemeterySept 30 1922

20 UNDERTAKER

ADDRESS

Jos. Jacobsens Son217 S. Bay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

81922

D-67931

HEALTH DEPARTMENT—CITY OF BALTIMORE

D-67931

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: JOHNS HOPKINS HOSPITAL ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Arthur Wilhelm

(a) RESIDENCE NO.

Parkton, Maryland ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown yrs. _____

ds. How long in U. S., if of foreign birth?

yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Virgil + Marian Wilhelm (parents)

6 DATE OF BIRTH (month, day, and year)

June 20, 1912

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

1036

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

117

(c) Name of employer

117

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Virgil Wilhelm

11 BIRTHPLACE OF FATHER (city or town)

Maryland

(State or country)

12 MAIDEN NAME OF MOTHER

Marian Co field

13 BIRTHPLACE OF MOTHER (city or town)

Maryland

(State or country)

14

Informant (Address)

JOHNS HOPKINS HOSPITALRecords

15

Filed

Robert P. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 26 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 25, 1922, to Sept 26, 1922.that I last saw him alive on Sept 26, 1922and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Acute endocarditis with cardiac decompensation.(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary)

Acute rheumatic fever(duration) yrs. 4 mos. 4 ds.

18 Where was disease contracted

if not at place of death?

At homeDid an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

H. H. Welch M. D.

, 19 (Address)

Johns Hopkins Hosp

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Grace Cemetery, CarrollSept 28 1922

20 UNDERTAKER

Ede Roy Stuffle

ADDRESS

1252 North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

22 1922

D 67932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 67932

1-PLACE OF DEATH

City of BALTIMORE: (No. *1801 N. Broadway* Ward) 8

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1801 N. Broadway* St.; yrs. *64* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH.

Oct 2 1922
(Month) (Day) (Year)

7-AGE.

68 yrs. *11* mos. *23* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

*Real Estate*9-BIRTHPLACE.
(State or Country).*Germany*

10-NAME OF FATHER.

*Alexander Stumpf*11-BIRTHPLACE OF FATHER.
(State or Country).*Germany*

12-MAIDEN NAME OF MOTHER.

*Barbara Houck*13-BIRTHPLACE OF MOTHER.
(State or Country).*Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary Metzger (Sister)

(Address)

2721 Fair Ave

15-

Robert H. ...

1922

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 25 or 26 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.)find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

*Natural Causes - Probably**Heart Disease*

(over)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. S. ...* M. D.(Coroner) *Sept 28* 1922 (Address) *1118 E. ...*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redeemer *Sept 29* 1922

20-UNDER-TAKER.

ADDRESS

Richard H. Cudley *438 E. North Ave*

N.B.—Every item of information should be in plain terms, so that it may be properly classified. Exact state CAUSE OF DEATH is very important. See instructions on back of certificate.

D 67933

HEALTH DEPARTMENT—CITY OF BALTIMORE D 67933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Bombar & Sime ST.

WARD)

2-FULL NAME

Thomas Sheridan

(a) RESIDENCE. NO.

2014 Oakley St.

WARD

New Bethlehem Pa.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ostra

6 DATE OF BIRTH (month, day, and year)

1912

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

11

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pa.

10 NAME OF FATHER

Thomas Sheridan

11 BIRTHPLACE OF FATHER (city or town)

Pa.

(State or country)

12 MAIDEN NAME OF MOTHER

Viola Troutman

13 BIRTHPLACE OF MOTHER (city or town)

Pa.

(State or country)

14

Informant (Address)

Georg. Verner
2014 Oakley St.

15

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/27 1922

17

I HEREBY CERTIFY, That I attended deceased from

9/20 1922, to 9/27 1922.

that I last saw him alive on 9/27 1922.

and that death occurred, on the date stated above, at 8:55 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. 1 1/2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Leon Friedman M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Bethlehem Pa Sept 29 22

20 UNDERTAKER

ADDRESS

Harry H. Witzke 15316 Lombard.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

P281972

D 67934 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 142 Landsdowne Lane ST. 70 WARD)

2-FULL NAME Anton Haib

(a) RESIDENCE

No. 142 Landsdowne Lane

ST. 70

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 6 - 1866

7 AGE

Years

Months

Days

If LESS than 1 day. hrs. or min.

56

3

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

Bartlett & Hyman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Valentine Heil

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Theresa Gontersbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

A. Benz. Heil 2407 N. Lombard St.

15

SEP 29 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

26, 1922, to 26, 1922,

that I last saw him alive on 26, 1922,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Left Brain

(Paralysis of Right side)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterial Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Gradual Hardening

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis of R side

(Signed) Thos. H. Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park.

Sept. 29 1922

20 UNDERTAKER

George L. Schwab

ADDRESS

2111 E. 4th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67935

CERTIFICATE OF DEATH.

D 67935

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 716 N. Monroe St. ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gottlieb Hanf.

(a) RESIDENCE No. 716 N. Monroe St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. 4 COLOR OR RACE White. 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of Catherine Hanf.

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1844

7 AGE Years 77 Months 10 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired.

9 BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER Nicholas Hanf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Lipman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Catherine Hanf. (wife) (Address) 716 N. Monroe St.

15 SEP 29 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1922.

17

I HEREBY CERTIFY, That I attended deceased from July 6th., 1922, to Sept 27, 1922, that I last saw him alive on Sept. 27, 1922, and that death occurred, on the date stated above, at 5.15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. 2 mos 21 ds.

CONTRIBUTORY Myocardial Insufficiency. (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? -----

Did an operation precede death? No Date of -----

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt, M. D.

9/28/22 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 Pauls Cem

DATE OF BURIAL 30

Sept 19 22

20 UNDERTAKER

Geo. W. Little

ADDRESS 27 (re)

Edman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67936

67936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 N. Chester ST., 8 WARD)2-FULL NAME William H. Warren(a) RESIDENCE NO. 1207 N. Chester ST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10th 18647 AGE Years 57 Months 3 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman(b) General nature of industry, business, or establishment in which employed (or employer) ok

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Henry Warren11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)12 MAIDEN NAME OF MOTHER Margaret Boyle13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)14 Informant Margaret Martin (Address) 1207 N. Chester St15 SEP 25 1922 Filed ROBERT H. HAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep 27 19 2217 I HEREBY CERTIFY That I attended deceased from Sept 25, 19 22, to Sept 27, 19 22.that I last saw him live on Sept 27, 19 22.and that death occurred, on the date stated above, at 4:30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physic(Signed) J. E. McCracken, M. D.(Address) 1301 N. Kent Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cem. DATE OF BURIAL Sept 20 19 22

20 UNDERTAKER ADDRESS

Frank A. Pink 915 N. Gay StCAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67937

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 E Preston ST., 9 WARD)

2. FULL NAME

Margaret A Foulds

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1208 E PrestonST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 97 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 30th 1825

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

97427

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER

James H Foulds

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

Elizabeth A Hall

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

14

Informant
(Address)Mrs Katie M Miller
1208 E. Preston St Baltimore

15

SEP 29 1922

ROBERT A. MAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 8, 1922, to Sept 28, 1922.that I last saw her alive on Sept 27, 1922.and that death occurred, on the date stated above, at 9. A. M.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis, marked
general(duration) 2 yrs. 2 mos. 2 ds.CONTRIBUTORY Nephritis, probably
(Secondary) sclerotic (duration) 2 yrs. 2 mos. 2 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? usual(Signed) Hubert G Knapp, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALGreenmount Cemetery

DATE OF BURIAL

Sept 30th 1922

20 UNDERTAKER

George Schilling & Sons

ADDRESS

1126 Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67938

CERTIFICATE OF DEATH.

D 67933

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 Paul ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Abraham Aronson (Aronson)

(a) RESIDENCE NO.

224 W. Virginia Ave.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

24 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male White Married

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Laura Aronson

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Piga Russia

10 NAME OF FATHER

Uriel Aronson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Piga

12 MAIDEN NAME OF MOTHER

Reine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Piga

14

Informant (Address)

Jack Lewis 1439 E. Baugh

15

SEP 29 1922

ROBERT R. RAUTEN

Baltimore Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1922

17

HEREBY CERTIFY, That I attended deceased from

July 5, 1922 to Sept 18, 1922that I last saw him live on Sept. 27, 1922and that death occurred, on the date stated above, at 3:35 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach liver and intestines(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 1922Was there an autopsy? noWhat test confirmed diagnosis? Autopsy section(Signed) J. W. Pearson, M. D., 19 (Address) 1102 H Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Sanction and

20 UNDERTAKER

Jack Lewis 1439 E. Baugh

DATE OF BURIAL

9/29 1922

ADDRESS

is very important. See instructions on back of certificate.

D 67939 HEALTH DEPARTMENT—CITY OF BALTIMORE D 67939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Proclaimed dead at*
City of BALTIMORE: (No. *St Joseph Hosp* St. *3* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Frank Zisk*
(Residence in Baltimore: No. *708 E Bond* St.; yrs. *18* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White*
6-DATE OF BIRTH *July 12 1869*
7-AGE *53* yrs. *2* mos. *14* ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Driver*
(b) General nature of industry, business, or establishment in which employed (or employer) *Geo & Elie Co*
9-BIRTHPLACE, (State or Country), *Poland*
10-NAME OF FATHER, *Nikolas Zisk*
11-BIRTHPLACE OF FATHER, (State or Country), *Poland*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER, (State or Country), *Poland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Barbara Zisk*
(Address) *708 E Bond St*

15-
SEP 29 1922 192... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 26 1922*
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* find that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH was as follows:
Heart Disease
fallen from street car at
Caroline & Eastern Ave while
going home & broken
CONTRIBUTORY to *St. Josephs Hosp*
(Secondary)
(Signed) *J. J. Potter* M. D.
(Coroner)
9-29-22 1922 (Address) *508 E North*
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Holy Rosary Sep 30 1922*
20-UNDERTAKER, ADDRESS *John M. Weber 1803 Bank*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67940

CERTIFICATE OF DEATH.

D 67940

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 Brantly Ave ST. 16 WARD)

2. FULL NAME

William J. Lenz

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1037 Brantly Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Alvina Lenz6 DATE OF BIRTH (month, day, and year) Mar 29 18627 AGE Years 60 Months 5 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stock Dept Manager, Y. B. Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

Knickerbocker Hotel

(c) Name of employer

J. S. Hulsbosch

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Henry Lenz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bermain

12 MAIDEN NAME OF MOTHER

Kathleen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bermain

14

Informant (Address)

Alvina Lenz
1037 Brantly Ave

15

Filed

SEP 29 1922

ROBERT H. FROSTER

Bureau Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 27 Sept 192217 I HEREBY CERTIFY, That I attended deceased from Sept 26 1922 to Sept 27 1922that I last saw him alive on Sept 27 1922and that death occurred, on the date stated above, at 850 a.m.

The CAUSE OF DEATH* was as follows:

Uremic Coma
infection

CONTRIBUTORY (duration) yrs. mos. ds.

Chronic Interstitial Nephritis (duration) 3 yrs. mos. ds.Where was disease contracted (if not at place of death?) UnknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Chemical(Signed) John A. Ryan M. D.19 (Address) 101 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St Pauls Violet Hills 9-30 1922

20 UNDERTAKER

Mrs Charles J. Holdrege101 N. Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. AGE should be stated EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67941

CERTIFICATE OF DEATH.

D 67941

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4502 Belmont Ave.* ST. *8* WARD)2-FULL NAME *Kula M Schmitt*(a) RESIDENCE. NO. *1803 N Washington* ST. *8* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *38* yrs. *5* mos. *27* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *J Henry Schmitt*6 DATE OF BIRTH (month, day, and year) *March 29 1884*7 AGE Years *38* Months *5* Days *27* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *- 037*

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto Md* (State or country)10 NAME OF FATHER *John F Mesz*11 BIRTHPLACE OF FATHER (city or town) *Balto Md* (State or country)12 MAIDEN NAME OF MOTHER *Elizabeth Muhl*13 BIRTHPLACE OF MOTHER (city or town) *Balto Md* (State or country)14 Informant *J Henry Schmitt* (Address) *1803 N Washington*15 Filed *SEP 29 1922* ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 26* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 30* 19 *22*, to *Sept 26* 19 *22*, that I last saw her alive on *Sept 26* 19 *22*, and that death occurred, on the date stated above, at *3:40 P* m.

The CAUSE OF DEATH* was as follows:

*Broncho-pneumonia*CONTRIBUTORY (Secondary) *Bulbar paralysis* (duration) yrs. mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *clinical* (Signed) *N. R. Luecke* M. D.19 PLACE OF BURIAL, CREMATION OR REMOVAL *Woodlawn Cem* DATE OF BURIAL *9-29* 19 *22*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 UNDERTAKER *Mrs. Charles G. Rohde* ADDRESS *600 N. Washington*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67942

1-PLACE OF DEATH

City of BALTIMORE: (No. 11 St. 11 Ward)

2-FULL NAME

(Residence in Baltimore: No. York Pa. St.; yrs. mos. ds.)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, white
5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Sept 30 1884
(Month) (Day) (Year)

7-AGE, 68 yrs. 11 mos. 28 ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Retired
(b) General nature of industry, business, or establishment in which employed (or employer), Farmer.

9-BIRTHPLACE, (State or Country), France

10-NAME OF FATHER, Joseph Hatterer

11-BIRTHPLACE OF FATHER, (State or Country), France

12-MAIDEN NAME OF MOTHER, —

13-BIRTHPLACE OF MOTHER, (State or Country), —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Son of John Hatterer

(Address), York Pa.

15- SEP 29 1922

Filed, 1922

ROBERT R. MAUTER, Registrar

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Sept. 28 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto Accident
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause: High

(Signed) J. C. Murray, M.D. (Coroner)
182 (Address) 1436 Bray

*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, York Pa. DATE OF BURIAL, Sept 29 1922

20-UNDERTAKER, J. C. Murray ADDRESS, 3000 E Balto.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67943

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 532 N. Monroe

ST.: 70 WARD)

2-FULL NAME Emma M. Monroe

(a) RESIDENCE. No. 532 N. Monroe

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 9 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Harold M. Monroe

6 DATE OF BIRTH (month, day, and year) Dec 25, 1849

7 AGE Years 72 Months 9 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md
Maryland

10 NAME OF FATHER William B. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore
Maryland

12 MAIDEN NAME OF MOTHER Emma Parsons

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore
Maryland

14

Informant (Address)

Joseph B. Cochran
532 N. Monroe St

15

Filed

SEP 29 1922

ROBERT A. KRAUTH
Registrar

Burial Permit No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 26, 1922, to Sept 27, 1922,

that I last saw him alive on Sept 27, 1922,

and that death occurred, on the date stated above, at 8-45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Arterio sclerosis and valvular heart disease

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

9-28-1922 (Address) 120 Disgrace St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oaklawn Cemetery

Sept 30 1922

20 UNDERTAKER

ADDRESS

John B. Spence 1325 N. Caroline St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

60° D 67944 HEALTH DEPARTMENT—CITY OF BALTIMORE 003 1880 67944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 15 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME August Meubert
(Residence in Baltimore: No. 2224 out Holly St. St.; yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <u>Male</u>	4-COLOR OR RACE <u>White</u>	5-Single, Married, Widowed, or Divorced. <u>Married</u> (Write the word.)
6-DATE OF BIRTH (Month) (Day) (Year)		
7-AGE <u>63</u> yrs. <u>63</u> mos. <u>63</u> ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <u>Retired</u>		
9-BIRTHPLACE. (State or Country). <u>Balto.</u>		
PARENTS.	10-NAME OF FATHER. <u>Geo. Meubert</u>	
	11-BIRTHPLACE OF FATHER. (State or Country). <u>Germany</u>	
	12-MAIDEN NAME OF MOTHER. <u>Unknown</u>	
	13-BIRTHPLACE OF MOTHER. (State or Country).	

14-THE ABOVE TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Meubert
(Address) 2224 out Holly St.

15-

SEP 29 1922

Regist. Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.
Sept 26 22
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

2 Cor. Amputated foot
due to
accident
2 Cor.
(Duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) stroke
(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) W. H. Riley M. D.
(Coroner)
Sept 28 1922 (Address) 1029 12th

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death 2 yrs. 2 mos. 2 ds. State 2 yrs. 2 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

London Park Cem Sept 29 1922
20-UNDERTAKER. ADDRESS
W. J. Tinkner & Sons 1000 North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67945

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N. Parrish ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced, state name of husband or (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 30 - 18707 AGE Years 52 Months 6 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

SEP 29 1922

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 1 -, 1922, to Sept. 27 -, 1922, that I last saw her alive on Sept. 27 -, 1922, and that death occurred, on the date stated above, at 8 P. m. The CAUSE OF DEATH* was as follows:Chronic interstitial nephritis(duration) about 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. T. McCarty, M. D., 19 (Address) 2410 Edmondson Cr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Gr.10/2/22 19

20 UNDERTAKER

ADDRESS

Samuel W. Chase - son1400 Mosher St

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67946

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 911 Whitecoat ST.: 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Samuel Leroy(a) RESIDENCE. NO. 911 Whitecoat ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19th 227 AGE Years Months Days If LESS than 1 day, hrs. or min. 3 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country) Md10 NAME OF FATHER Abraham Samuel Leroy11 BIRTHPLACE OF FATHER (city or town) Westmoreland Co. (State or country) Va12 MAIDEN NAME OF MOTHER Maggie Layton13 BIRTHPLACE OF MOTHER (city or town) Mary Point (State or country) Va14 Informant Maggie Layton (Address) 911 Whitecoat St.15 Filed SEP 29 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-28 192217 I HEREBY CERTIFY, That I attended deceased from Sept 27th 1922 to Sept. 28th 1922 that I last saw him alive on Sept 28th 1922 and that death occurred, on the date stated above, at 4:30 P. m. The CAUSE OF DEATH* was as follows:
Pneumonia(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? examined(Signed) John H. Bell M. D.Address 1824 Guilford St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL 9/30/2220 UNDERTAKER Sam'l H. Chase ADDRESS 1400 N. Charles

PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67947 HEALTH DEPARTMENT--CITY OF BALTIMORE
CERTIFICATE OF DEATH

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1305 Richardson ST. 24 WARD)

2-FULL NAME Michael Hambach

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1305 Richardson St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male. 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6-DATE OF BIRTH November 25, 1860 (Month) (Day) (Year)

7-AGE 61 yrs. 10 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) General

9-BIRTHPLACE (State or country) Austria Hungary.

10-NAME OF FATHER Alexander Hambach

11-BIRTHPLACE OF FATHER (State or country) Austria Hungary

12-MAIDEN NAME OF MOTHER Annie Sanan.

13-BIRTHPLACE OF MOTHER (State or country) Austria Hungary

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Catherine Hambach

(Address) 1305 Richardson

15. SEP 29 1922 ROBERT R. KRAUTER, Dark Permit

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept. 27, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1922, to Sept. 27, 1922, that I saw him alive on Sept. 27, 1922, and that death occurred on the date stated above, at 3:40 P. M. The CAUSE OF DEATH* was as follows:

Myocarditis (Duration) yrs. mos. ds. 3
Contributory Acute Degeneration of Heart (SECONDARY) (Duration) yrs. mos. ds. 2 mos.
(Signed) Thos. H. Stevens, M. D. Sept 28, 1922 (Address) 2878 Harford Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Sept. 30, 1922

20-UNDERTAKER Margaret E. Lippin ADDRESS 422 Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67948

CERTIFICATE OF DEATH.

REGISTERED NO. C. 67948

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2629 W. Franklin

ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

WM. H. Brown

(Residence in Baltimore: No. 2629 W. Franklin

St.: 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

M

4-COLOR OR RACE,

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Dec. 22, 1860
(Month) (Day) (Year)

7-AGE,

61 yrs. 9 mos. 6 ds.

IF LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

none of

9-BIRTHPLACE, (State or Country),

Cal.

10-NAME OF FATHER,

WM. H. Brown

11-BIRTHPLACE OF FATHER (State or Country),

Cal.

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Cal.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

Chas. A. Brown

(Address).....

2629 W. Franklin

15-

Filed.....

191

ROBERT R. KRAUTER,

Bureau of Health

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 15 1920, to Sept 28 1922,

that I saw him alive on Sept 26 1922,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency
(Duration) 2 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

Myocardial Insufficiency
(Duration) 2 yrs. 1 mos. 1 ds.

(Signed) Gustav G. Johnson M. D.

9/29, 1922 (Address) 2629 W. Franklin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Western

DATE OF BURIAL,

Sept. 30, 1922

20-UNDERTAKER

WM. Coak, 502 E. North Ave.

ADDRESS

502 E. North Ave.

Important. See instructions on back of certificate.

STATE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. PHYSICIANS should

D 67949 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D 67949

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. 2221 1/2 x Holly Street St. Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2221 1/2 x Holly Street St.; yrs... life mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5-SINGLE

6-MARRIED

7-WIDOWED

8-DIVORCED

(Write the word.)

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

192

ROBERT H. KRAUTER,

Deputy Registrar

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month)

(Day)

(Year)

I HEREBY CERTIFY, that I took charge of the remains described above, held a (inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said (inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed)

192

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67950

CERTIFICATE OF DEATH

129 D 67950

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1425 Bolton

ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Laura Eugene Fugle

(Residence in Baltimore: No. 1425 Bolton St.

St. 87 yrs. 8 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Widowed (Write the word)

6 DATE OF BIRTH Jan. 5, 1835 (Month) (Day) (Year)

7 AGE 87 yrs. 8 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Baltimore Md.

10 NAME OF FATHER Charles Walsh

11 BIRTHPLACE OF FATHER Ballo. Md.

12 MAIDEN NAME OF MOTHER Rebecca Brown

13 BIRTHPLACE OF MOTHER Ballo. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. S. H. Thompson (daughter)

(Address) 1425 Bolton St.

15 SEP 29 1922 ROBERT R. MAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 28, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to Sept. 28, 1922, that I saw her alive on Sept. 28, 1922, and that death occurred, on the date stated above, at 11 P. m. The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Definite (Duration) yrs. mos. ds.

Contributory (SECONDARY) Definite (Duration) yrs. mos. ds.

(Signed) Harry H. Arthur M. D. Sept. 29, 1922 (Address) 1426 W. Lenoir St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Date of Burial

20 UNDERTAKER ADDRESS

AM F. WOODEN, 108 W. NORTH AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67951

CERTIFICATE OF DEATH.

D 67951

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Leist(a) RESIDENCE NO. 1424 Anthony St

(Usual place of abode)

ST. 10 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1855

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

67

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8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant

(Address)

Hospital Records,

Municipal Hospital.

15

Filed

SEP 29 1922

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 5, 19 22, to Sept. 27, 19 22.

that I last saw him alive on September 27, 19 22.

and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clyde M. M. D.

9/29/22 (Address)

Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Cross

DATE OF BURIAL

Oct 2 1922

20 UNDERTAKER

Finkler & Finkler

ADDRESS

1739

Eagan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67952

CERTIFICATE OF DEATH.

179 D 67952

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *121 S. East Ave.* ST., *16* WARD)

2-FULL NAME

Mary K. Heiner

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

121 S. East Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female White**Married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*John Heiner*

6 DATE OF BIRTH (month, day, and year)

May 18, 1869

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*53**4**10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Washington D. C.*

10 NAME OF FATHER

Louis Eckert

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

not known

14

Informant
(Address)*John Heiner
121 S. East Ave.*

15

Filed

28-1922

ROBERT A. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 28 1922*

17 I HEREBY CERTIFY, That I attended deceased from

Sept 3 1922 to *Sept 28 1922*that I last saw him alive on *Sept 28 1922*and that death occurred, on the date stated above, at *5:40 A. m.*

The CAUSE OF DEATH* was as follows:

Endocarditis(duration) *1* yrs. *2* mos. ds.CONTRIBUTORY
(Secondary)(duration) *2* yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date of *no*

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Maxwell L. Wagner

(Address)

3115 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Int. Cemetery

DATE OF BURIAL

Oct 1 1922

20 UNDERTAKER

Jirkler & Jirkler

ADDRESS

Eager

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D 67953

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1221 Park Ave ST., 11 WARD)

2-FULL NAME

Mary Morse

(a) RESIDENCE NO.

1221 Park Ave

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds.

ST., WARD (If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Caucasian 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Aug 18 1897

7 AGE 18 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 137

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

(c) Name of employer

9 BIRTHPLACE (city or town) S Carolina (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant James Morse (Address) 1221 Park Ave

15 Filed 29 19 22 ROBERT A. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1922, to Sept 28, 1922, that I last saw her alive on Sept 28, 1922, and that death occurred, on the date stated above, at 3:10 p.m. The CAUSE OF DEATH* was as follows:

Acute pneumonia
phlebotomy & exhaustion

(duration) 2 yrs. 4 mos. 1 ds. CONTRIBUTORY (Secondary) General exposure

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? physical exam

(Signed) Ed Hall, M. D.

, 19 (Address) 426 E 73rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt. Auburn Cemetery DATE OF BURIAL Oct-2 1922

20 UNDERTAKER Mrs Robert A Elliott ADDRESS 1725- Ashland Ave

D 67954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D 67954

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Edmondson Ave. 17 WARD)

2-FULL NAME

Isabella V. Schutty

(a) RESIDENCE NO.

710 Edmondson Ave.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm H. Schutty

6 DATE OF BIRTH (month, day, and year)

May 13, 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

4

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

Michael Kettler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Elizabeth Ducey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

York

14

Informant (Address)

Wm H. Schutty 710 Edmondson Ave

15

Filed Robert J. Harrison

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 30, 1922, to Sept 27, 1922.

that I last saw her alive on Sept 26, 1922.

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

cardiac asthma

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Geo W. Hemminger, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hampstead Md

Sept 30, 1922

20 UNDERTAKER

ADDRESS

Wm J. Kettler & Sons.

North St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922

Is very important. See instructions on back of certificate.

D 67955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2830 Rayner Ave. 16 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon E. Rof

(Residence in Baltimore: No. 2830 Rayner Ave St. 4 yrs. 10 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE. white 5-Single, Married, Widowed, or Divorced. single

6-DATE OF BIRTH. Nov. 5, 1917
(Month) (Day) (Year)

7-AGE. 4 yrs. 10 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer). (child)

9-BIRTHPLACE, (State or Country). Ba. Co. Md.

10-NAME OF FATHER. Melvin D. Rof

11-BIRTHPLACE OF FATHER. Ba. Co. Md.

12-MAIDEN NAME OF MOTHER. Margaret E. Oldham

13-BIRTHPLACE OF MOTHER. Denma.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Melvin D. Rof

(Address) 2830 Rayner Ave.

15- Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to this death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gun shot wound of brain (accidental)

(Duration) yrs. mos. ds.

(Signed) J. D. Hennessy (Coroner.)

(Address) 2830 Rayner Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Woodlawn Sept 30, 1922

20-UNDERTAKER, ADDRESS

Geo W Little 2700 E. Edwards Ave

RECORD OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Bay View* St. *No* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Loraine Ave, Essex, Balto. Co. Md.* St., yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, Divorced, (Write the word.) *Single*

6-DATE OF BIRTH *Oct 17* 19*20* (Month) (Day) (Year)

7-AGE, *1* yrs. *11* mos. *10* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). *Infant*

9-BIRTHPLACE, (State or Country). *Balto, Md*

10-NAME OF FATHER, *Elmer F. Bantz*

11-BIRTHPLACE OF FATHER, (State or Country). *Balto, Md*

12-MAIDEN NAME OF MOTHER, *Catherine Neubager*

13-BIRTHPLACE OF MOTHER, (State or Country). *Balto, Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Information) *Elmer F. Bantz*
(Address) *Loraine Ave, Essex*

15- *Robert F. Bartlett* Registrar.
Filed *Sept 28* 19*20*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 27* 19*20* (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said *Inquiry* find that said deceased came to *death* (topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain

(Duration) *2 1/2* hrs.

CONTRIBUTORY *Struck by car* (Secondary) *Truck*

(Signed) *Charles B. Brown* M. D.

(Address) *Charles B. Brown*

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). In the place of death, yrs., mos., ds. State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

St. Barnabas *Sept 29* 19*20*

20-UNDERTAKER, ADDRESS

Wm C. Miller *233 Jefferson*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67957

CERTIFICATE OF DEATH.

67957

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 1/2 W. Susatoya WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lena Ethel Brazier

(a) RESIDENCE

742 1/2 W. Susatoya

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 5 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofWalter R. Brazier6 DATE OF BIRTH (month, day, and year) March 30, 1880

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.42529

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

Edward Carter

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER

May Hilland13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore

14

Informant
(Address)Walter R. Brazier
742 1/2 W. Susatoya St.

15 Filed

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 26, 19 22 to Sept 29, 19 22that I last saw her alive on Sept 29, 19 22and that death occurred, on the date stated above, at 380 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration)

yrs.

mos.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?XDid an operation precede death? no Date of XWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. Van Kippenberg M. D.

, 19

(Address)

501 Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Lorraine CemeteryOct 2 19 22

20 UNDERTAKER

ADDRESS

Wilbur W. Shriver1018 E. Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67958

CERTIFICATE OF DEATH.

D 67958

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 E. Mt. Vernon Place ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Stuart Abbott

(a) RESIDENCE NO. 14 E. Mt. Vernon Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 4 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. John W. Abbott

6 DATE OF BIRTH (month, day, and year) April 18, 1879

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 43 5 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trained Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Montreal, Canada (State or country)

10 NAME OF FATHER Robert Stuart

11 BIRTHPLACE OF FATHER (city or town) Scotland (State or country)

12 MAIDEN NAME OF MOTHER Jane Reid

13 BIRTHPLACE OF MOTHER (city or town) Scotland (State or country)

14 Informant Miss Elizabeth Stuart (Address) 217 E. 27th. St. N. Y.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/28 1922

17 I HEREBY CERTIFY, That I attended deceased from 9/26, 1922, to 9/28, 1922.

that I last saw h.f.f. alive on 9/28, 1922.

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage
Broncho-Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Walter A. Walker, M. D.

9/29, 1922 (Address) 900 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn Cemetery 9/30, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

801922

Mortel 207523 210773

D 67959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 W. Franklin ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr. R. Stehli

(a) RESIDENCE. NO.

1408 W. Franklin ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

Life ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Ms Catherine G. Stehli

6 DATE OF BIRTH (month, day, and year)

Aug. 22, 1882

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.4015

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clk.

(b) General nature of industry, business, or establishment in which employed (or employer)

B & O Railroad.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto.md.

10 NAME OF FATHER

Henry A. Stehli

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

md.

12 MAIDEN NAME OF MOTHER

Florence Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md.

14

Informant

(Address)

Catherine G. Stehli1408 W. Franklin St.

301922

19

Burial Permit 4100 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1922, to Sept. 27, 1922,that I last saw him alive on Sept 27, 1922,

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 3 mos. ds.CONTRIBUTORY
(Secondary)Exhaustion(duration) yrs. 1 mos. ds.

18 Where was disease contracted

if not at place of death?

UnknownDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

Physical exam.

(Signed)

Herbert C. Blake, M. D.

(Address)

1014 W. La Jolla

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western CemeterySept 30 1922

20 UNDERTAKER

ADDRESS

Josiah Syfer 1600 ar north

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 67960

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 67960

CERTIFICATE OF DEATH

91-002

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No.

ST. 15 WARD)

2-FULL NAME

(Residence in Baltimore: No.

St. 61 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5

SINGLE,
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

Widow

6 DATE OF BIRTH

April 20, 1846

7 AGE

76 yrs. 5 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)House work
0379 BIRTHPLACE
(State or country)

Lynchburg Va

10 NAME OF FATHER

James Doud

11 BIRTHPLACE OF FATHER
(State or country)

Lynchburg Va

12 MAIDEN NAME OF MOTHER

Mary Buford

13 BIRTHPLACE OF MOTHER
(State or country)

Lynchburg Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Gertrude Boone

(Address)

4009 Belle Ave

15

Robert F. Harrison,

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 29, 1922

17. I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to Sept 29, 1922

that I saw him alive on Sept 28, 1922

and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) 5 yrs. mos. ds

Contributory (SECONDARY) Pneumonia Hypostatic

(Duration) 2 yrs. mos. ds.

(Signed) Abraham Gark M. D.

Sept 29, 1922 (Address) 2731 Parkway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Oct 2, 1922

20 UNDERTAKER ADDRESS

Josiah Syper 1600 W North

B-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

P3 01922

D 67961

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67961

CERTIFICATE OF DEATH.

1-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balt Ten Hoop, ST. 24 WARD)

2. FULL NAME

Emmer E. Walter

(a) RESIDENCE NO.

1408 Riverside Ave

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ramona Walter

6 DATE OF BIRTH (month, day, and year)

Mar 17, 1889

7 AGE

33 yrs

Years

Months

8

Days

22

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Prakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

Railroad Employee

(c) Name of employer

BYD R.R.

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

John L. Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Maria Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

South Balt Ten Hoop

15

Date

30 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1922, to Sept 29, 1922.that I last saw him alive on Sept 28, 1922.and that death occurred, on the date stated above, at 745A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Exhaustion(duration) 15 mos. 15 ds.

CONTRIBUTORY (Secondary)

Typhoid Fever(duration) 22 yrs. 22 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) R. M. Hughes, M. D., 19 (Address) South Balt Ten Hoop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Western Cemetery

20 UNDERTAKER

Joseph Syfer 1600 N. North

DATE OF BURIAL

Oct 2 1922

ADDRESS

D 67962

CERTIFICATE OF DEATH.

73

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Robert Bent

St. Paul Apartments

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 19 12

I HEREBY CERTIFY, That I attended deceased from
Sept. 27, 1922, to Sept. 29, 1922.

that I last saw him alive on Sept. 29, 1922.

6 DATE OF BIRTH (month, day, and year) *July 29, 1944*

and that death occurred, on the date stated above, at 12 A.m.

7 AGE	Years	Months	Days	If LESS than
-------	-------	--------	------	--------------

The CAUSE OF DEATH* was as follows:

74

1 day, hrs
or min.

Paralysis agitans

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hagerstown
(State or country) Md.

10 NAME OF FATHER Robert J. Brent

11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Louisiana*

12 MAIDEN NAME OF MOTHER *Mattilda Laurson*

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant **JOHNS HOPKINS HOSPITAL.**

Informant
(Address)

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-pneu-
monia (duration) yrs. mos. 10 ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?.... No special test

(Signed) W. H. Herman, M. D.

2-29, 1922 (Address) John Florkins Flork

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Registrar

D 67963

HEALTH DEPARTMENT—CITY OF BALTIMORE

67963

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

30-1922

Robert E. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 26 1922, to Sept 29 1922, that I last saw him alive on Sept 29 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Harrison, M. D.

9/30, 1922 (Address) 846 W 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Marys St Oct 2 22

20 UNDERTAKER

St Marys 3539 Fall Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67964

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 Brant St

ST.: 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Frances V. Green

(a) RESIDENCE. No. 601 Brant St

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred 5 yrs. mos. ds.

How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8-1881

7 AGE Years 41 Months 20 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Co Md

10 NAME OF FATHER

Joseph Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Chaplinstown Pa

12 MAIDEN NAME OF MOTHER

Sarah Barney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Co Md

14

Informant (Address)

Jos Smith 601 Brant St

301922

Robert P. HARRISON,

Registrar

Dated 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 27 1922, to Sept 28 1922,

that I last saw her alive on Sept 28 1922,

and that death occurred, on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) George H. Brown M. D.

(Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cemetery Sept 30 1922

20 UNDERTAKER ADDRESS

H. S. Marshall 3539 Fall Rd.

D 67965

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67965

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 41 Southern ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 41 Southern

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 1 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 27, 19 22 to Sept 28, 19 22.that I last saw him alive on Sept 28, 19 22.and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Toxicemia(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Clara J. Jones M. D.19 (Address) 4206 Hampden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

EP 301327

D-87966

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67966

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

JOHNS HOPKINS HOSPITAL ST. 17 WARD

2-FULL NAME

Harris Quickel

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1618 St. Paul

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Esther Quickel

6 DATE OF BIRTH (month, day, and year)

Sept 1 - 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

10 NAME OF FATHER

Preston Quickel

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant: JOHNS HOPKINS HOSPITAL.
(Address)

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 29th, 1922, to Sept 30th, 1922, that I last saw him alive on Sept 30th, 1922.

and that death occurred, on the date stated above, at 3:25 a. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - left frontal

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67968

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edith M. Nichols(Residence in Baltimore: No. 613 Saratoga St.; 1 yrs., 1 mos., 12 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Caucasian 5-SINGLE, MARRIED, Single WIDOWED, DIVORCED, (Write the word.)6-DATE OF BIRTH, Aug 17, 1922 (Month) (Day) (Year)7-AGE, 1 yrs., 12 mos., 12 ds. If LESS than 1 day, ...hrs. or...min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, None (b) General nature of industry, business, or establishment in which employed (or employer), None9-BIRTHPLACE, (State or Country), MD10-NAME OF FATHER, Richard Melliner11-BIRTHPLACE OF FATHER (State or Country), Unknown12-MAIDEN NAME OF MOTHER, Elyse Nichols13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sylvia Nichols(Address) 613 Saratoga

15-

Filed Robert E. Harrison

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 25 1922, to Sept 29 1922, that I saw her alive on Sept 28 1922, and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) 4 yrs., 4 mos., 4 ds.

CONTRIBUTORY (Secondary)

(Signed) William E. Custon M. D.
Sept 29, 1922 (Address) 762 Dolphin

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs., 1 mos., 12 ds. In the State 1 yrs., 1 mos., 12 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, mt auburn DATE OF BURIAL, Sept 30, 192220-UNDERTAKER, R B Gross 1405 McElderry ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

30 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 67969

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2524 Federal ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth V. Allen

(a) RESIDENCE NO.

2524 Federal

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female WhiteWidowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 23rd 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6949

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Joseph B Jenkins

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Elizabeth A Hall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant

(Address)

John G. Allan
2524 Federal St

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 27, 1922, to Sept. 27, 1922,that I last saw him alive on Sept. 27, 1922,and that death occurred, on the date stated above, at 1:50 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Salivary test

(Signed)

Albert J. Singmaster, M. D.(Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

Robert J. Turner

ADDRESS

144 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of COUPA-TION is very important. See instructions on back of certificates.

301922

Serial Form 101-001

D 67970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 67970

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 Stockton ST. 70 WARD)

2-FULL NAME

Dallie Ringgold

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

510 Stockton ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofWilliam H. Ringgold

6 DATE OF BIRTH (month, day, and year)

1873

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.50

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self 0419 BIRTHPLACE (city or town)
(State or country)M.C.

10 NAME OF FATHER

Christopher Wardell

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

M.C.

12 MAIDEN NAME OF MOTHER

Ann Wardell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

M.C.

14

Informant

(Address)

William H. Ringgold
510 Stockton

15

Filed

Robert F. HAPPELTON

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1922

17

I HEREBY CERTIFY, That I attended deceased from
May 1, 1922, to Sept 28, 1922,
that I last saw her alive on Sept 26, 1922,
and that death occurred, on the date stated above, at 11 30 m.

The CAUSE OF DEATH* was as follows:

Heart Insufficiency(duration) 1 yrs. 6 mos. 1 ds.CONTRIBUTORY
(Secondary)Ac. dilatation of heart
(duration) 1 yrs. 1 mos. 1 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? Physical findings

(Signed)

W. A. Krell, M. D.9/29, 1922 (Address)Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn CemeteryOctober 1, 1922

20 UNDERTAKER

ADDRESS

Mrs. Katie R. Williams1114 St. Saratoga

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

01922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67971

CERTIFICATE OF DEATH.

D 67971

159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 S. Second ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alfouse Setkewicz

(a) RESIDENCE NO.

702 S. SecondST., 26 WARD

(Usual place of residence)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 28/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Benedict Setkewicz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Poland

12 MAIDEN NAME OF MOTHER

Caroline Midura

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Poland

14

Informant

(Address)

Mr. Theodora Flury702 S. 2 St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 28, 1922, to Sept. 29, 1922.that I last saw him alive on Sept. 29, 1922.and that death occurred, on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of heart
(Foramen ovale)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Geo. J. Lockwood

M. D.

, 19 (Address) 806 S. 3 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Forest Hill Cemetery

20 UNDERTAKER

Lilly and Ziehl

DATE OF BURIAL

Sept 30 1922

ADDRESS

403 S. 10th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be stated EXACTLY. PHYSICIANS should state exact statement of occupation. AGE should be stated EXACTLY. See instructions on back of certificates.

30 1922

D 67972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003 D 67972

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Garrett Hospital WARD)2-FULL NAME Baby Olin (No Christian name)(a) RESIDENCE NO. Since birth in Women's Ward Garrett Hospital(Usual place of abode)
Length of residence in city or town where death occurred yrs. 2 mos. 28 ds. (If non-resident give city or town and State) yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 29, 19227 AGE Years Months Days If LESS than 1 day, hrs. or min.
2 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Women's Hospital Baltimore Md
(State or country)10 NAME OF FATHER Harry Arthur Olin11 BIRTHPLACE OF FATHER (city or town) Chicago Ill.
(State or country)12 MAIDEN NAME OF MOTHER Katherine V. Price13 BIRTHPLACE OF MOTHER (city or town) Grafton W. Va.
(State or country)14 Informant Mrs. Katherine Olin
(Address) 619 University Parkway15 Filed Robert E. Harrison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 27 19 2217 I HEREBY CERTIFY, That I attended deceased from June 29, 19 22, to Sept 27, 19 22that I last saw him alive on Sept 20, 19 22and that death occurred, on the date stated above, at 7:40 p.m.

The CAUSE OF DEATH* was as follows:

hydrocephalus(duration) yrs. 2 mos. 28 ds.CONTRIBUTORY spina bifida
(Secondary)(duration) yrs. 2 mos. 28 ds.18 Where was disease contracted if not at place of death? congenitalDid an operation precede death? no Date ofWas there an autopsy? none

What test confirmed diagnosis?

(Signed) Walter Zastep, M. D.19 (Address) Lakeview Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

To Johns Hopkins UnivSept 29 1922

20 UNDERTAKER

ADDRESS

Charles Bagley m

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PARENTS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

67973

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 928 E. Shaw St. 11 Ward)

Registered No. C.

2-FULL NAME

(Residence in Baltimore: No. 928 E. Shaw St. 10 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female colored
4-COLOR OR RACE, colored
5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Aug 1867
(Month) (Day) (Year)

7-AGE, 55 yrs., mos., ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va.

10-NAME OF FATHER, John Bannister

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Muburn

13-BIRTHPLACE OF MOTHER, (State or Country), Muburn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amma Buggs

(Address) 928 E. Shaw St.

15- Robert P. Harrison,

30, 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 27, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

myocardial degeneration

(Duration) 3 yrs., mos., ds.

CONTRIBUTORY (Secondary) no history

(Signed) J. J. Hennessy, M. D.

(Coroner.)

Sept 30, 1922 (Address) 282 E. Lombard Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Ambrose Sept 29, 1922

20-UNDERTAKER, ADDRESS

John H. Loder 143 St.

D 67974

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph robinson(a) RESIDENCE No. 527 Numan st.

(Usual place of abode)

ST. 17 WARDLength of residence in city or town where death occurred Unknown yrs. Life mos.(If non-resident give city or town and State)
ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofMary Robinson
Not given6 DATE OF BIRTH (month, day, and year) 18747 AGE Years 48 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Joseph Robinson11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records
(Address) 1111 N. E. St.15 Filed 19 Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 28, 192217 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 19 22, to Sept. 28, 1922.that I last saw him alive on Sept. 28, 1922.and that death occurred, on the date stated above, at 1.10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 11 mos. ds.CONTRIBUTORY Pulmonary hemorrhage
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis L. Delaguerre, M. D.9-28-22 (Address) Municipal Tbc. Hospital

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

St. Luke's Oct 2, 192220 ADDRESS 678Samuel C. Cusly

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67975

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67975

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Dollie Taylor(a) RESIDENCE NO. 643 Raburg st.

(Usual place of abode)

ST. 4 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19847 AGE Years 38 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Virginia10 NAME OF FATHER Acy Taylor11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Virginia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records (Address) M.T.H.15 Filed Robert P. Harrison, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 26, 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1922, to Sept. 26, 1922.that I last saw him alive on Sept. 26, 1922.and that death occurred, on the date stated above, at 5.25 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Unknown if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Francis J. Gadsdalen, M. D.9-27-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. John'sSept. 26, 1922

20 UNDERTAKER

ADDRESS 578Samuel M. MundyM.B. Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67976

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

522-2 Lakewood Ave. 1st WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Blara Sullivan

(a) RESIDENCE. NO.

522-7 Lakewood ST. 1st WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

2 yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

William Sullivan

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20

1901 Sept

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

at home, 0.37

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Baltimore

2nd Ward

10 NAME OF FATHER

Joseph H. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

Germany

12 MAIDEN NAME OF MOTHER

Catherine H. Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

Germany

14

Informant (Address)

Wm Sullivan 522-1 Lakewood

15

Filed

Robert E. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept 25 1920

17

I HEREBY CERTIFY, That I attended deceased from

Sept 10, 1920, to Sept 24, 1920,

that I last saw him alive on Sept 24, 1920,

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia

over

(duration)

yrs.

mos. 18

ds.

CONTRIBUTORY (Secondary)

Childbirth

(duration)

yrs.

mos. 8

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

W. L. Long

M. D.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross, German Hill

Oct 2 1920

20 UNDERTAKER

ADDRESS

Nemell Duffel & Son 375 Bm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

301922

BURIAL PERMIT CLERK

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Pulmonary Tuberculosis
Positive Sputum

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67977 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 905 E. Pratt St., 3 Ward)

Registered No. C.....

2-FULL NAME Andrew Bonalle

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 905 E. Pratt St.; yrs., 1 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, W 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH, Feb 4 1912 (Month) (Day) (Year)

7-AGE, 7 yrs., 25 mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Infant (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Pa

10-NAME OF FATHER, Bloss Bonalle

11-BIRTHPLACE OF FATHER, (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Teresa Ritz

13-BIRTHPLACE OF MOTHER, (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Teresa Bonalle

(Address) 905 E. Pratt St.

15- Robert E. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 29 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Intestinal Indigestion (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) (Signed) Thos. J. Fortson M. D. (Address) Baltimore

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs., mos., ds. In the State, yrs., mos., ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St Vincent Sep 30 1922

20-UNDERTAKER, ADDRESS

Memell Dyfelor 378 N

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67978

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: JOHNS HOPKINS HOSPITAL ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Brown(a) RESIDENCE NO. 3805 Foster Ave BALTO, ST., MARYLAND WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofJane Eppley (Grandmother)6 DATE OF BIRTH (month, day, and year) April 9, 19047 AGE Years Months Days If LESS than 1 day, hrs. or min.
18 5 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None9 BIRTHPLACE (city or town)
(State or country)NoneMaryland10 NAME OF FATHER William E. Brown11 BIRTHPLACE OF FATHER (city or town)
(State or country)BaltimoreMaryland12 MAIDEN NAME OF MOTHER Jennie Pugh13 BIRTHPLACE OF MOTHER (city or town)
(State or country)BaltimoreMaryland14 Informant JOHNS HOPKINS HOSPITAL

(Address)

Records15 Filed Robert F. Hartz

16

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 25, 1922 to Sept 28, 1922, that I last saw him alive on Sept 28, 1922, and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Hypophyseal tumor —
Brain tumor(duration) 4 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? at homeDid an operation precede death? Yes Date of Sept 27Was there an autopsy? YesWhat test confirmed diagnosis? X-ray, hypophyseal alio

(Signed)

J. L. Reichert, M. D.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Oak LawnOct 1 1922

20 UNDERTAKER

ADDRESS

Les E. LeachNorth Harbor

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 67979

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital. St. 7 Ward 185)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Herbert M. Rollison.(Residence in Baltimore: No. 933 N. Washington St. St.; yrs. 30 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Married, Widowed, or Divorced. (Write the word.)6-DATE OF BIRTH, August 27, 1882. 1. (Month) (Day) (Year)7-AGE, 40 yrs. 1 mos. 1 ds. If LESS than 1 day,hrs. or....min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Craneman
(b) General nature of industry, business, or establishment in which employed (or employer). American Sug Ref.9-BIRTHPLACE, (State or Country). Kent Co Md.10-NAME OF FATHER, John Rollison.11-BIRTHPLACE OF FATHER, (State or Country). Kent Co Md.12-MAIDEN NAME OF MOTHER, Ella Coleman.13-BIRTHPLACE OF MOTHER, (State or Country). Kent Co Md.14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Rhoda M. Rollison. (wife).(Address) 933 N. Washington St.

15.

16-Robert P. Harrison,
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 28, 1922. 192. (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.The CAUSE OF DEATH* was as follows:
Fracture of the skull & right femur.
Occidental fall from a crane.(Duration)yrs.mos.ds.
CONTRIBUTORY Shock.(Secondary) Charles St.
(Signed) Charles St. M. D.
Sept. 29, 1922. (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.yrs.mos.ds. In the State.yrs.mos.ds.Where was disease contracted, if not at place of death? Accident
American Sugar Refinery. Sept. 28, 1922.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Oaklawn DATE OF BURIAL, Oct. 2, 192220-UNDERTAKER, Funkler & Funkler ADDRESS 1739 Eager St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67980

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67980

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 213 W 25th

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-29-22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4 yrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

G. W. Rand

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

M. Glenn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

John W. Rand
213 W 25th St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/29 19 22

17

I HEREBY CERTIFY, That I attended deceased from

9/28, 19 22 to 9/29, 19 22that I last saw him alive on 9/29, 19 22and that death occurred, on the date stated above, at 12:20 P.m.

The CAUSE OF DEATH* was as follows:

Deep Throat { Raynaud
Pharyngeal
Coronary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Culture(Signed) W. C. Martin, M. D.19 (Address) Syden Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Clare Sept 30 19 22

20 UNDERTAKER

ADDRESS

William C. 5026 N. 1st

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 67981

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2216 E Madison*

ST.,

WARD)

2-FULL NAME *Marion M. Kee Nies*

(a) RESIDENCE NO. *2216 E Madison*
(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred

7 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced, (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 29, 1915

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

7

9

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

at school

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Balto Md

10 NAME OF FATHER

Fredk C Nies

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Balto

12 MAIDEN NAME OF MOTHER

Kate Heiger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Balto

14

Informant
(Address)

Fredk C Nies
2216 E Madison

15

Filed

19

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

114

ST.,

WARD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 27 1922*

17

I HEREBY CERTIFY, That I attended deceased from
Sept 25, 19*22* to *Sept 27*, 19*22*,
that last saw him alive on *Sept 27*, 19*22*.

and that death occurred, on the date stated above, at *7:10* a.m.

The CAUSE OF DEATH* was as follows:

Chlor. Crisis acute

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

30 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

Sept 26 19*22*

ADDRESS

2008

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hk.

D 67982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67982

CERTIFICATE OF DEATH.

100-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2217 Lakewood Ave ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 2217 Lakewood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE M. 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Oda Ferguson

6 DATE OF BIRTH (month, day, and year) Dec 12, 1849

7 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk B & O RR

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

James S. Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Oda Ferguson 2217 Lakewood

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29 1922

17

I HEREBY CERTIFY, That I attended deceased from

9-29, 1922, to 9-29, 1922.

that I last saw him alive on 9-29, 1922.

and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

BRONCHOPNEUMONIA

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John S. Dorsey, M. D.

, 19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

Cathedral Ave

DATE OF BURIAL

Sept 26, 22

20 UNDERTAKER

J. S. Sweeney

ADDRESS

2008 Orleans

67983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67983

CERTIFICATE OF DEATH.

45

67983

D 67983

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003. Girard Ave. 13 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

David Brice

(a) RESIDENCE No.

2003. Girard Ave. ST., WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male. White Widowed

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Brice

6 DATE OF BIRTH (month, day, and year)

Sept 22, 1865

7 AGE

Years

Months

Days

67

✓

7

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Carroll Co. Md.

10 NAME OF FATHER

James Brice

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Annie Cook

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Carroll Co. Md.

14

Informant

(Address)

Mrs Charles Martins

2003. Girard Ave.

15

Filed

OCT 1 - 1922

ROBERT H. MAUTER,

Baltimore Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 29, 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 22, 1922, to Sept 29th, 1922, that I last saw him alive on Sept 28th, 1922, and that death occurred, on the date stated above, at 9:50 P. M.

The CAUSE OF DEATH* was as follows:

General tubercular Cancer

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. P. Leneuf, M. D.

9/30, 1922 (Address)

1527 Madison St E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Winfield Carroll Co. Md. Oct 1, 1922

20 UNDERTAKER

ADDRESS

Greenworth & Son 3617 Chestnut Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 14 WARD)2-FULL NAME Solonion F. Kirwan(a) RESIDENCE, NO. 1914 Linden Ave. - ST. _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15-1858

7 AGE

63

Years

Months

9

Days

15

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Sullivan F. Kirwan

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Susan Travers

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

(Address)

Wm F. Kirwan1914 Linden Ave

15

Filed

Oct 1-1922ROBERT R. MAISTERPermit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1922, to Sept. 30, 1922,that I last saw him alive on Sept. 30, 1922,and that death occurred, on the date stated above, at 2:18 A. m.

The CAUSE OF DEATH* was as follows:

Internal hemorrhoids - Polypoid growth.(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hemorrhage -(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of 9/25/22Was there an autopsy? noWhat test confirmed diagnosis? Clinical cause(Signed) Anthony V. Buchner, M. D., 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cambridge MdOct 2 1922

20 UNDERTAKER

Harry W. EhlenADDRESS 1944W. North

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 67985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D 67985

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hehren Herz* ST. *70* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Israel Pleet*(a) RESIDENCE. No. *406 S. Pulaski* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Lena Pleet*

6 DATE OF BIRTH (month, day, and year)

1891

7 AGE

31 Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Russia*

10 NAME OF FATHER

Salomon Pleet

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Mollie

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

*Jack Lewis
1439 E. BALDWIN*

15

Filed

19

OCT 1-1922

ROBERT A. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 30, 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Sept. 24, 1922, to Sept. 30, 1922*that I last saw him alive on *Sept. 30, 1922*and that death occurred, on the date stated above, at *6 P. m.*

The CAUSE OF DEATH* was as follows:

Brain tumor (?)

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Moses Tellman*, M. D.19 (Address) *Hebrew Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hehren Herring Run 10/1/22

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. BALDWIN

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67986

CERTIFICATE OF DEATH.

D 67986

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5731 Novane Ave ST. 27 WARD)2-FULL NAME Mary Mowinkel(a) RESIDENCE NO. 5731 Novane Ave ST.

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 8 ds.How long in U. S., if of foreign birth? 49 yrs. 11 mos. 8 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of Andrew Mowinkel6 DATE OF BIRTH (month, day, and year) Oct 21, 1872

7 AGE

Years 49Months 11Days 8

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER John A Haupt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Hertie Haupt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14

Informant Mrs. Cecilia Bennett(Address) 5731 Novane Ave

15

ROBERT H. MAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 11, 19 22, to Sept 28, 19 22that I last saw her alive on September 28, 19 22and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
Carcinoma of Stomach
Carcinoma of Omentum
(duration) 1 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY

(Secondary)

Infarction (duration) 5 yrs. 5 mos. 5 ds.

18 Where was disease contracted

if not at place of death? sameDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Autopsy of Mass.(Signed) S. W. Bisher, M. D.Address 502 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cem Oct 2 19 22

20 UNDERTAKER

ADDRESS

Wm. J. Kuehn

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67987

CERTIFICATE OF DEATH.

91-002

D 67987

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 E Hairmyer Ave ST., WARD)

2-FULL NAME Barnett Jantoff

(a) RESIDENCE NO. 2010 E Hairmyer Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/11/57

7 AGE Years 71 Months 7 Days — If LESS than 1 day, — hrs. — or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) off

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant A. Bennett (Address) 2010 Hairmyer Ave

15 ROBERT R. KRAUTER, Registrar

OCT 1-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1916, to Sept 30, 1922, that I last saw him alive on Sept 30, 1922, and that death occurred, on the date stated above, at 11.10 P.M.

The CAUSE OF DEATH* was as follows:

Atherosclerosis
myocarditis

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ernest E. Meyer, M. D.

10/1, 1922 (Address) 7438 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Hebrew Southern Ave 19/1 1922

20 UNDERTAKER

A. Lissner & Co E Balto St

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67988

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67988

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins* St. *8* Ward)

Registered No. C.....

2-FULL NAME.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1511 N. Dallas* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Black* 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH. *Sept 25* 19*22* (Month) (Day) (Year)

7-AGE, *1* yrs. *0* mos. *5* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *Miss* (b) General nature of industry, business, or establishment in which employed (or employer) *do*

9-BIRTHPLACE. (State or Country). *Baltimore*

PARENTS. 10-NAME OF FATHER. *James Jones* 11-BIRTHPLACE OF FATHER. (State or Country). *New Jersey* 12-MAIDEN NAME OF MOTHER. *Mildred Taylor* 13-BIRTHPLACE OF MOTHER. (State or Country). *St Marys Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) *Mildred Jones* (Address) *1511 N. Dallas St*

15. *OCT 1-1922* *ROBERT R. KRAUTER* Filed 19*22* *Burial Permit* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 30* 19*22* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows: *Acute mitral heart indigestion* *Portally Brought - Pneumonia* *Hospital report* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) *J. L. Taylor* M. D. (Coroner.) *9-30-1922* (Address) *1511 N. Dallas St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds. Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. *Ashbury Cemetery* DATE OF BURIAL, *Oct-1* 19*22*

20-UNDERTAKER. *Mrs Robert A Elliott* ADDRESS *1725 Ashland Av*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67989

HEALTH DEPARTMENT—CITY OF BALTIMORE

167 D 67989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

2228 Cambridge St.

Registered No. C.....

City of BALTIMORE: (No.)

St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Sophia Single

(Residence in Baltimore: No.)

2228 Cambridge St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced, (Write the word.)

Married

6-DATE OF BIRTH

Nov 20 1882

(Month) (Day) (Year)

7-AGE

39

yrs. 10 mos. 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

9-BIRTHPLACE

(State or Country)

Balt. Md

10-NAME OF FATHER

John Robert

11-BIRTHPLACE OF FATHER

(State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

George Single

(Address)

2228 Cambridge St.

15

Filed

OCT 1-1922

ROBERT R. KRAUTER

Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 29 1922

(Month) (Day) (Year)

I HEREBY CERTIFY That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Inhaling Gas

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.

(Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mount Carmel Oct 2 1922

20-UNDERTAKER, ADDRESS

Jacobs Heerman 325 Broad way

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67990

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 501 Roland Ave ST. 13 WARD)

2-FULL NAME

John C. Bell

(a) RESIDENCE NO.

501 Roland Ave

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos.

ds. How long in U. S., if of foreign birth? 72 yrs. 9 mos. 20 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bettie Gore Bell

6 DATE OF BIRTH (month, day, and year) Dec 9 - 1849

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 72 9 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto County Md

10 NAME OF FATHER

John Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Elizabeth Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Mrs Bessie Gore Bell
501 Roland Ave

15

Filed

1-1-1922

ROBERT H. KRANTZ

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 21 1922 to Sept 29 1922 that I last saw him alive on Sept 29 1922 and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Monchial Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 3
Directly from Hemorrhoids

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of Sept 28

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. D. Lightner M. D.
211 N. Lamar St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Thomas. Balto. Burial Oct 1 1922

UNDERTAKER

ADDRESS

John O. Littlefield 1201 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67991

CERTIFICATE OF DEATH.

D 67991

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Edmondson Ave WARD)2-FULL NAME Walter J. Reynolds(a) RESIDENCE. NO. 1831 Edmondson ST., WARD.Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE White 5 Single Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown7 AGE Years Months Days If LESS than 1 day, hrs. or min. About 45

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md10 NAME OF FATHER John W. Reynolds11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore N.C.12 MAIDEN NAME OF MOTHER Catherine Gayhall13 BIRTHPLACE OF MOTHER (city or town) (State or country) McKaysland14 Informant Miss Lillie Reynolds (Address) 1831 - Edmondson15 ROBERT R. RAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 192217 I HEREBY CERTIFY, That I attended deceased from Sept 27, 1922, to Oct 1, 1922, that I last saw him alive on Sept 30, 1922, and that death occurred, on the date stated above, at 1240 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral HemorrhageCONTRIBUTORY (Secondary) Pulmonary Aneurysm (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? NoDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Thorax(Signed) Thorax, M. D.(Address) 939 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cem Oct 4 1922

20 UNDERTAKER ADDRESS

Indian Cook 502 E. North

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Vouuord 939 W. Fayette }

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. Weyerhaeuser Timber Co. Fairfild Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Reinhardt Gunkel.

(Residence in Baltimore: No. 5th & Hillcrest Sts. Brooklyn St., yrs. 38 mos. 38 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, October 7, 1884. 1. (Month) (Day) (Year)

7-AGE, 37 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Crane foreman (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany.

PARENTS. 10-NAME OF FATHER, Do not know. 11-BIRTHPLACE OF FATHER, (State or Country), Do not know. 12-MAIDEN NAME OF MOTHER, Do not know. 13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Elizabeth Gunkel. (wife). (Address) 5th. & Hillcrest Sts. Brooklyn.

15- OCT 1-1922 ROBERT R. KRAUTER, Filed 192 Bureau Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, September 29, 1922. 192 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows: Mangled about the body. Accidentally run over by a movable crane.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Chas. M. Reinhardt M. D. (Coroner.) Sept. 29, 1922 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill DATE OF BURIAL, Oct. 3/22

20-UNDERTAKER, Wm Leever ADDRESS, 502 E. North Ave.

D 67993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.; WARD) 9

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *St. George's - St. Mary's Co. Md.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.) Single

6-DATE OF BIRTH,

July 7, 1916
(Month) (Day) (Year)

7-AGE,

6 yrs. 2 mos. 23 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country) *St. Mary's Co. Md.*

10-NAME OF FATHER,

John F. Sheehan

11-BIRTHPLACE OF FATHER,

(State or Country) *Calvert Co. Md.*

12-MAIDEN NAME OF MOTHER

Ceelia C. Carroll

13-BIRTHPLACE OF MOTHER,

(State or Country) *St. Mary's Co. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mr. John F. Sheehan
St. Mary's Co. Md.

15-

OCT 1-1922

ROBERT R. KRAUTER,

Filed

191

Baltimore City Health Department Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept. 30, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept. 18, 1922 to Sept. 30, 1922

that I saw him alive on Sept. 30, 1922

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

(Duration) *Approx. 24 hrs.*CONTRIBUTORY (Secondary) *Sarcoidosis - Heart**Primary Sarcoidosis of Left Kidney*(Signed) *J. W. K. K. K.* M. D.

101... (Address)...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Poplar Hill, Baltimore, Md.*20-UNDERTAKER *Henry Hoeck, Sun*DATE OF BURIAL, *Oct. 2, 1922*ADDRESS *1301 E. Eager St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 67994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67994

CERTIFICATE OF DEATH.

I. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1412 N Mulberry St. 49 WARD)

2. FULL NAME *Nanora A. Whelan*

(a) RESIDENCE NO. 1412 N Mulberry St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May 1, 1870*7 AGE Year Months Days *52 4 28* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *John Conroy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Nanora Conroy*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *James J. Whelan Jr. 1412 N. Mulberry St.*

15

OCT 1 - 1922 ROBERT R. KAUTER, Registrar

Bertel Perotti Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 29 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Sept 24, 1922* to *Sept 29, 1922*, that I last saw her alive on *Sept 29, 1922* and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH* was as follows:

*Pericarditis - Myocarditis
Cholecystitis -*(duration) yrs. mos. ds. *7 ds.*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *1 ds.*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *Edw. V. Caspary*, M. D.9/30, 1922 (Address) *24 N. Mulberry St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Cross Cemetery Oct 3 1922

20 UNDERTAKER

ADDRESS

Henry P. Branning & Son 517 N. Schroeder

NATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 67995 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. **D 67995**

1-PLACE OF DEATH

CITY OF BALTIMORE (No. **517 N. 39th St.** ST. **13** WARD)

2-FULL NAME

Abraham Louis Pace

(a) RESIDENCE NO.

517 N. 39th St.

ST. **13** WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. **7** mos. **18** ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb. 13-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

James S. Pace

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Co. Maryland

12 MAIDEN NAME OF MOTHER

Margaret Starn

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Co. Maryland

14

Informant (Address)

James S. Pace 517 N. 39th St.

15

Filed

ROBERT H. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 1-1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 21st, 1922, to Oct. 1st, 1922,

that I last saw him alive on Oct. 1st,

and that death occurred, on the date stated above, at 5:50 A. M.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. **10** ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) **George S. Cross**, M. D.

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

St. Mary's (Hampden)

DATE OF BURIAL

Oct. 3 1922

ADDRESS

Horace H. Surges 363 Falls Rd

1. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67996

CERTIFICATE OF DEATH.

47 D 67996

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3700 Elm Ave. ST. 13 WARD)

2-FULL NAME

Mary E. Bowen

(a) RESIDENCE NO.

3700 Elm Ave. ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Frank Bowen

6 DATE OF BIRTH (month, day, and year)

Aug. 31-1867

7 AGE

55

Months

29

Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Co. Maryland

10 NAME OF FATHER

John J. Houser

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER

Mary A. Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Co. Maryland

14

Informant (Address)

John Frank Bowen 3700 Elm Ave

15

DECEASED 1922

ROBERT H. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 29 1922

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1922, to Sept. 29, 1922, that I last saw him alive on Sept. 26, 1922, and that death occurred, on the date stated above, at 12:10 A. M.

The CAUSE OF DEATH* was as follows:

Leucemia of throat.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cancer of lungs

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 16/22

Was there an autopsy? No

What test confirmed diagnosis? Exam of throat and tumor

(Signed) R. B. Houser, M. D.

, 19 (Address) 3543 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

St. Mary's (Hampton) Oct. 2 1922

20 UNDERTAKER

ADDRESS

Horace H. Burgee 3631 Killebrew

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 67997

D 67997

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ST. WARD)

2-FULL NAME

(a) RESIDENCE

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1922

ROBERT A. KNAUTH

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from 9/29/22, 1922, to 9/30/22, 1922, that I last saw him alive on 9/30/22, 1922, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary

(duration)

yrs.

mos.

7

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Oct. 2th 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas

425 S Paca St.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

67998
D 67998

HEALTH DEPARTMENT—CITY OF BALTIMORE

67998

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*
CITY OF BALTIMORE: (No. *Cor. Lombard & Greene* ST. *4* WARD)

REGISTERED NO. *117 D 67998*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Dorothy Susannah Sears.*

(a) RESIDENCE. NO. *West River -*

ST. *4* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 ☒ Single, ☐ Married, ☐ Widowed, or ☐ Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *August 6 - 1912.*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
10 years.

8 OCCUPATION OF DECEASED *Solvent Girl*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *West River - Md.* (State or country)

10 NAME OF FATHER *Charles Sears.*

11 BIRTHPLACE OF FATHER (city or town) *Calvert Co. Md.* (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Lucie B. Sears.*

13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)

14 Informant *Charles Sears* (Address) *West River*

15 Filed *1-1-1922*

ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10 - 1 - 1922*

17 I HEREBY CERTIFY, That I attended deceased from *September 28, 1922, to December 1, 1922,* that I last saw her alive on *December 1, 1922,* and that death occurred, on the date stated above, at *1.25 P. m.*

The CAUSE OF DEATH* was as follows:

Perforated appendix with diffuse peritonitis

(duration) yrs. mos. *2* ds.

CONTRIBUTORY *Diffuse Broncho Pneumonia* (Secondary)

(duration) yrs. mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *9/28/22*

Was there an autopsy? *yes*

What test confirmed diagnosis? *Physical Symptom & Signs*

(Signed) *Robert H. Krauter* M. D.

10-1-1922 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

B & W Hospital 10/2/22

20 UNDERTAKER ADDRESS

148 West St. Annapolis

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

15-8649
#D 67999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 67999

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Iola Taylor

(a) RESIDENCE NO. 617 S. Wolfe St. City ST. 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced

HUSBAND of
WIFE of

Felix + Anastasia Taylor

6 DATE OF BIRTH (month, day, and year) July 7, 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
1 2 ?

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

447

(c) Name of employer

447

9 BIRTHPLACE (city or town) (State or country)

Baltimore
Maryland

10 NAME OF FATHER

Felix Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Anastasia Sirowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

OCT 2 - 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29, 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 25, 1922, to Sept 29, 1922, that I last saw her alive on Sept 29, 1922, and that death occurred, on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Prima (duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John M. Weber 1823 Bank

Spec. 1-10-21 M&T 1560 Bks.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1560 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68000
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

91-002 D 68000

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 1221 Pennsylvania Ave ST. _____ WARD _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
51 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Oklahoma

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oklahoma

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) OKlahoma

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed OCT 2 - 1922 ROBERT H. KRAUTH, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 29 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept. 8, 19 22, to Sept. 29 19 22.
that I last saw him alive on Sept. 29 19 22.

and that death occurred, on the date stated above, at 11:10 A.M.

The CAUSE OF DEATH* was as follows:

Heart Block

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Yes Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. M. Wheeler M. D.

9/30/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MUTUAL DATE OF BURIAL Oct 2 19 22

20 UNDERTAKER Samuel E. Egan ADDRESS Pa 916

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

158548
2 25 PM
D 68001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-003 D 68001

1-PLACE OF DEATH

CITY OF BALTIMORE: JOHNS HOPKINS HOSPITAL ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Clarke

(a) RESIDENCE NO.

1000 Angyle Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male Black

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 18-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

—

2

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland
Charles Clarke

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Viola Reddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

2-1922

Robert H. Kauter
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 20, 1922, to Sept 29, 1922

that I last saw him alive on Sept 29, 1922

and that death occurred, on the date stated above, at 2 25 PM

The CAUSE OF DEATH* was as follows:

Acute pyelonephritis

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. A. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

My Auburn Ave

20 UNDERTAKER

Daniel Earls

DATE OF BURIAL

Sept 29 1922

ADDRESS

916

Oct 2-1922

Spec. -1-10-21 M&T-1500 Bks.

THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. -1-10-21 M&T-1500 Bks.

D 68002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

90 D 68002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 552 W. Conway ST., 22 WARD)

2-FULL NAME

Martha Lucas

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

552 W. Conway ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

37 yrs. 7 mos. 21 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joshua Lucas

6 DATE OF BIRTH (month, day, and year)

Feb. 7, 1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

37

7

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Coop. 021

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Private Homes.

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

William Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Lavinia

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant (Address)

Leon Lucas 552 W Conway St

15

Filed

1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 28, 1922

17

I HEREBY CERTIFY, That I attended deceased from

July, 2, 1922, to Sept, 28, 1922.

that I last saw him alive on Sept, 28, 1922.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral + Aortic Endocarditis

(duration)

10 mos

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Wain Franklin M. D.

9/29/22 Address

122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

122 W. Lee St

Oct 2, 1922

20 UNDERTAKER

ADDRESS

Daniel Easton Pa ar

THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68003 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68003

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2708 Riggs Ave. ST. 16 WARD)

2-FULL NAME William Jammer

(Residence in Baltimore: No. 2708 Riggs Ave. St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, July 26, 1868 (Month) (Day) (Year)

7-AGE, 54 yrs. 2 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Clerk. (b) General nature of industry, business, or establishment in which employed (or employer), Patterson Hardware

9-BIRTHPLACE, (State or Country), Balto Md.

10-NAME OF FATHER, Jacob Jammer

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret Schirmer

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Daniel Leroy Jammer

(Address) 2708 Riggs Ave.

15-

Filed 12-1922 101 ROBERT R. KRAUTER

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 30, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide by gas

a phylisiatry (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. T. Hammsay, M. D. (Coroner.)

Sept. 30, 1922 (Address) 2802 Edmond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Em. DATE OF BURIAL, Oct. 2, 1922

20-UNDERTAKER, Mrs. New John H. Tengel & Son 801 W. Bay St.

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Dec. 1922 500 Bks.

D 68004

158692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 68004

1-PLACE OF DEATH

CITY OF BALTIMORE, JOHNS HOPKINS HOSPITAL, ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Terret.

(a) RESIDENCE NO. 2124 Fleet St. City ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

Unknown yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND or WIFE of

Mrs. Charles Terret (father)

6 DATE OF BIRTH (month, day, and year) March 15, 1910

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
12 6 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

#7

(c) Name of employer

#7

9 BIRTHPLACE (city or town) (State or country)

England

10 NAME OF FATHER

Charles Terret

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Jessie Trist

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14 Informant JOHNS HOPKINS HOSPITAL

(Address)

Records

15

Filed

1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1, 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 27, 1922 to Oct 1, 1922.

that I last saw him alive on Oct 1, 1922.

and that death occurred, on the date stated above, at 3:00 A. M.

The CAUSE OF DEATH* was as follows:

Rheumatic Fever, Cardiac Hypertrophy, Dilatation, Mitral + Aortic Valvular Disease, Bronchopneumonia

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. W. Lounsbury M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

20 UNDERTAKER

H. Sander Lons

DATE OF BURIAL

Oct 2, 1922

ADDRESS

1210 Read St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68005

D 68005

CERTIFICATE OF DEATH.

143-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2241 Cecil Ave. ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Isabelle Jewes

(a) RESIDENCE NO.

2241 Cecil Ave. ST. 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

(or) WIFE of

W. Arthur Jewes

6 DATE OF BIRTH (month, day, and year)

June 12th 1892

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.30318

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore
md

10 NAME OF FATHER

James Dean

11 BIRTHPLACE OF FATHER (city or town)

Balt
md

12 MAIDEN NAME OF MOTHER

Catherine Sheel

13 BIRTHPLACE OF MOTHER (city or town)

Balt
md

14

Informant
(Address)W. Arthur Jewes
2241 Cecil Ave.

15

Filed

OCT 2 - 1922ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 26, 1922, to Sept. 30, 1922, that I last saw her alive on Sept. 30, 1922, and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration)

yrs.

mos.

7 6 3CONTRIBUTORY
(Secondary)Spontaneous Miscarriage
occurred Sept. 28 (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

W. C. Sandrock

M. D.

X, 1922 (Address) 1242 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

DATE OF BURIAL

Oct 3rd 1922

20 UNDERTAKER

George Schilling & Sons 1126 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68006

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D 68006
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 n - Bond ST., 7 WARD)

2-FULL NAME

John Thompson

(a) RESIDENCE NO.

714 n - Bond

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

66 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

66

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

Driver

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Scorus Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

John W. Thompson 1702 Parker Place

15

File

OCT 2 - 1922

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-29-1921

17

I HEREBY CERTIFY, That I attended deceased from 9-27-1921, to 9-29-1921, that I last saw him alive on 9-29-1921, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration)

yr.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yr.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis?

Fabry's test (2 sugar)

(Signed)

W. H. Cargill

M. D.

10-1-1921 (Address)

611-7-Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel

DATE OF BURIAL

Oct 2 1922

ADDRESS 1802

20 UNDERTAKER

John W. Henderson

C. M. Mounsey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68007

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D 68007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 406 Patapasco Ave (Brooklyn) ST. 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edna J. Schaefer

(a) RESIDENCE NO.

406 Patapasco Ave (Brooklyn) ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND or WIFE of

Clifton L. Schaefer

6 DATE OF BIRTH (month, day, and year)

July 23 1886

7 AGE

Years 36

Months 2

Days 6

If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

At Home

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John F. Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Frederick Md

12 MAIDEN NAME OF MOTHER

Amelia C. Browning

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Frederick Md

14

Informant (Address)

Clifton L. Schaefer 406 Patapasco Ave (Brooklyn) ST.

15

Filed

OCT 2-1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 29 1922

17

I HEREBY CERTIFY, That I attended death from December 2nd 1917 to September 29th 1922.

that I last saw her alive on September 29th 1922 and that death occurred, on the date stated above, at 6:45 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. 9 mos. 27 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

At place of death

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Sputum examination

(Signed)

Harry Heibel

10/1, 1922

(Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Cedar Hill Cemetery

Oct 2 1922

John F. Denny

715 Light St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68008 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 D 68008

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *St. Joseph's Hospital 16*

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. WARD)

2. FULL NAME *Walter Wells*

(a) RESIDENCE No. *926 whatcoat* ST. WARD

(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1895*

7 AGE *47* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Maryland*

10 NAME OF FATHER *Leonidas Wells*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Mary Bell*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14 Informant *Mary Wells* (Address) *926 whatcoat st*

15 Filed *OCT 2 - 1922* ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept. 29, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept. 15, 1922* to *Sept. 29, 1922*, that I last saw him alive on *Sept. 29, 1922*, and that death occurred, on the date stated above, at *5:15 P. M.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY *Ruptured aneurysm of aorta* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *none*

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *P.S. & S.*

(Signed) *W. T. Riley*, M. D.

. 19 (Address) *1639 N. Broadway*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Not Buried* DATE OF BURIAL *Oct. 2, 1922*

20 UNDERTAKER *James H. Wynn* ADDRESS *1303*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68009

CERTIFICATE OF DEATH.

129 D 68009

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 McHenry ST. 21 WARD)

2-FULL NAME

Annie M. Hugh

(a) RESIDENCE NO. 903 McHenry ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 7 mos. 1 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female

white

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thomas M. Hugh

6 DATE OF BIRTH (month, day, and year)

Feb 29-1859

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

63

7

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt, Md.

10 NAME OF FATHER

Michael Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Michael M. Hugh 903 McHenry St.

15

Filed

OCT 2-1922

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/30/22

17

I HEREBY CERTIFY, That I attended deceased from

9/22/22, 19 to 9/30/22

that I last saw him alive on 9/30/22, 19

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

Full bladder Dis. + Cholesterol

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) Samuel J. Long M. D.

(Address) 910 N. Lomb

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cem

Oct 3rd 1922

20 UNDERTAKER

ADDRESS

John J. Conway & Son

901 Hollins

21

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68010

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home & Inf.*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (Not *Broadway & Fairmont* ST. *6* WARD)2-FULL NAME *Rev. Edward M. Morgan*(a) RESIDENCE NO. *Church Home & Inf.* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Unknown*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years *82* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Virginia*10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

14

Informant

15

Filed

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7/27/1922*

17

I HEREBY CERTIFY, That I attended deceased from

7/27/1922, to *9/26/1922*that I last saw him alive on *8/26/1922*and that death occurred, on the date stated above, at *7 A.M.*

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical method*(Signed) *Robert B. Rice*, M. D., 19 (Address) *Church Home & Infirmary*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Roudin Park Oct 2, 1922

UNDERTAKER

ADDRESS

John O. Hatcher 1201 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D 68011

CERTIFICATE OF DEATH.

90 D 68011

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4905 Ferndale ST. 28 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 4905 Ferndale ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Walter L. Gray

6 DATE OF BIRTH (month, day, and year) May 22, 1848

7 AGE Years 74 Months 4 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER

Daniel Sapp

11 BIRTHPLACE OF FATHER (city or town)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Rebecca Owens

13 BIRTHPLACE OF MOTHER (city or town)

La.

14

Informant

(Address)

Charles N. Crowder 4905 Ferndale Ave.

15

Filed

19

ROBERT R. KRAUTER, Registrar

Sanial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 29, 1922, to Sept 30, 1922,

that I last saw him alive on Sept 30, 1922,

and that death occurred, on the date stated above, at 2.30 P.m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Infarction

CONTRIBUTORY (Secondary)

duration) yrs. mos. 2 ds. Arterial Sclerosis Hypertension

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones M. D.

19 (Address) 222 Argos St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Louisa Park Oct 2 1922

20 UNDERTAKER

ADDRESS

John O. Mitchell 1201 N. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD.

Aug 9. Luker
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68012

CERTIFICATE OF DEATH.

31

D 68012

1-PLACE OF DEATH

City of BALTIMORE: (No. *On Pa. R. R. Train near Bay View*) Ward)

Registered No. C.....

2-FULL NAME

Aug. W. Luker
(Residence in Baltimore: No. *1841 Milton* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *man* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. *Wid*
(Write the word.)

6-DATE OF BIRTH. *Sept 14* 1854
(Month) (Day) (Year)

7-AGE. *68* yrs. *2* mos. *15* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Gen. hauling*
(b) General nature of industry, business, or establishment in which employed (or employer). *020*

9-BIRTHPLACE. *Balto*
(State or Country).

10-NAME OF FATHER. *G. H. Luker*

11-BIRTHPLACE OF FATHER. *Germany*
(State or Country).

12-MAIDEN NAME OF MOTHER. *L. Scheinman*

13-BIRTHPLACE OF MOTHER. *Germany*
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *P. Luker*

(Address) *1841 Milton*

15-*OCT 2-1922*

Filed *192* ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Sept 19* 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Palmar. Hernia large
Probably tubercular
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *W. H. H. H.* M. D. (Coroner) *W. H. H. H.* 1922. (Address) *W. H. H. H.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Greenmount Cemetery Oct 2nd 1922

20-UNDERTAKER. ADDRESS

E. J. Manning, Inc. 1938 E. Lafayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68013

CERTIFICATE OF DEATH.

90 D 68013

1-PLACE OF DEATH

Municipal Corp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 76 WARD)

2-FULL NAME

Wm. E. Hays

(a) RESIDENCE No.

Baltimore

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Corp. Records

15

Filed

19

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10-1-1922

17

I HEREBY CERTIFY, That I attended deceased from

4-1-1922 to 10-1-1922

that I last saw him alive on Oct 1, 1922

and that death occurred, on the date stated above, at 4:54 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Alcoholism

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde McNeill, M. D.

10/1/22 (Address) Municipal Corp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Washington St. G.

DATE OF BURIAL

Oct 2 1922

20 UNDERTAKER

Henry Lutz

ADDRESS

N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68014 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH. 572 D 68014

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Municipal Hospital ST., 12 WARD) REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Pugh
(a) RESIDENCE NO. 2310 Hunter St. ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE Years Months Days If LESS than 1 day, hrs or min.
56 -- --

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) 021
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Joseph Pugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed Oct 2-1922 19 ROBERT R. KRAUTER Registrar
Serial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1922 to Sept. 30, 1922, that I last saw him alive on Sept. 30, 1922, and that death occurred, on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH* was as follows:
Diabetic gangrene of rt foot & leg.
(duration) yrs. mos. ds. 24

CONTRIBUTORY (Secondary) Diabetic gangrene of stump
(duration) yrs. mos. ds. 10

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-16-22

Was there an autopsy? No

What test confirmed diagnosis? Laboratory + Examination

(Signed) J. Richardson Payne, M. D.

9/30/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

20 UNDERTAKER Samuel Heenrich

DATE OF BURIAL Oct 2, 1922
ADDRESS 578 N. Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68015

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68015

CERTIFICATE OF DEATH.

31

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital WARD 17)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Richardson

(a) RESIDENCE NO. 1043 Argyle ave. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years 35 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Matthew Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Amos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M. T. H.

15 Filed 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 30, 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 19 22, to Sept. 30, 1922, that I last saw him alive on Sept. 30, 1922, and that death occurred, on the date stated above, at 10:45 p.m. The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis X-ray (Signed) Francis L. Badagliacca M. D.

10-2-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

At Auburn

10/4 1922

20 UNDERTAKER

ADDRESS

Sam'l. Thackeray

W. B. Dale

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68016

CERTIFICATE OF DEATH.

100-001 D 68016

1. PLACE OF DEATH

Robt Garrett Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 27 N. Carey ST., 16 WARD)

2. FULL NAME

Pearl Garrison

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 1102 Woodley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 2 1922

7 AGE

Years

Months

Days

29

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)City
John Harrison

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

Balto

(State or country)

12 MAIDEN NAME OF MOTHER

Pearl Harris

13 BIRTHPLACE OF MOTHER (city or town)

Balto

(State or country)

14

Informant

(Address)

Mrs Pearl Garrison
1102 Woodley St

15

Filed

OCT 2 - 1922

ROBERT A. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 2 1922

17

I HEREBY CERTIFY, That I attended deceased from
Sept 30, 1922, to Oct 2, 1922.

that I last saw her alive on Oct 2, 1922.

and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)

Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted

if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Redf M. D.

10/2, 1922 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Olivet Cemetery

Oct 2 1922

20 UNDERTAKER

ADDRESS

Wm J. Tuckner & Sons

110 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 D 68017

1-PLACE OF DEATH

D 68017

REGISTERED No.

CITY OF BALTIMORE: (No. Municipal Hospital ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Calvin Ford

(a) RESIDENCE No.

1913 Orleans St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Colored

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1890

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

32

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Chauffeur

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore, Md.

10 NAME OF FATHER

Georgex Ford

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Rosanna Bedford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore, Md.

14

Informant
(Address)Hospital Records,
Municipal Hospital

15

Filed 2-19-22ROBERT M. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Sept. 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 25, 19 22, to Sept. 27, 19 22.

that I last saw him alive on Sept. 27, 19 22.

and that death occurred, on the date stated above, at 7:10 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
(duration) yrs. 6 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clyde W. Miller M. D.

7/27/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3/18

UNIVERSITY OF MARYLAND

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 68018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hosp.

CITY OF BALTIMORE: (No.

Eastern Ave

ST.

WARD)

2-FULL NAME

George W. Smith

(a) RESIDENCE NO.

26 River

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Brooklyn, Md.

10 NAME OF FATHER

Moses Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Peterson Edward

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Hospital Records

15

Filed

19

Burial Permit Book

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9-26-1922

17

I HEREBY CERTIFY, That I attended deceased from

9-23-1922, to 9-26-1922,

that I last saw him alive on 9-26-1922,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Uremic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings

(Signed) Richardson J. M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.

Sept 30 1922

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68019

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68019

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *2047 Keyser* St., *8* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2047 Keyser* St.; yrs., *56* mos., *8* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

Black

Single
Married
Widowed
or Divorced
(Write the word.)

6-DATE OF BIRTH

Oct 28 19*22*
(Month) (Day) (Year)

7-AGE

62 yrs. *11* mos. *18* ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laundress

9-BIRTHPLACE

(State or Country),

Virginia

10-NAME OF FATHER

Charles Allen

11-BIRTHPLACE OF FATHER

(State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Quith

13-BIRTHPLACE OF MOTHER

(State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Wm. Jones (Daughter)
2047 Keyser St

15-

Filed

OCT 2-1922

102

ROBERT R. KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Sept 30 19*22*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held at *my house*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-

topsy find that said deceased came to *death*
topsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Failure

Probably (Duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Allen* M. D.

(Coroner)

1922 (Address) *508 E. Mount*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Form for usual residence

19-PLACE OF BIRTH OR REMOVAL

Charlotte Co Va
random station

DATE OF BURIAL

Oct 4 19*22*

20-UNDERTAKER

Edward Bryon

ADDRESS

1631 Orleans

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.

Spec.—1-10-21—M&T—1500 Bks.

10. 68020 HEALTH DEPARTMENT—CITY OF BALTIMORE
D 68019

CERTIFICATE OF DEATH.

129 10. 68020
D 68019
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes* ST. *43* WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 21, 1922, to Oct. 1, 1922,

that I last saw her alive on Oct. 1, 1922,

and that death occurred, on the date stated above, at 8:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic & Acute Nephritis
Uremia - Hypertension

not known (duration) yrs. mos. ds.

CONTRIBUTORY Cardiac failure
(Secondary) pulmonary edema - 3 ds.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. C. Caldwell, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL
Parkwood Cemetery Oct 4 1922

20 UNDERTAKER

ADDRESS

Henry Brock & Son 1301 E. Gay

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2202 Allendale Rd ST. 47 WARD)

2-FULL NAME

Anna Taylor

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2202 Allendale Rd

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 4th 1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54625

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Joseph Dudley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Anna Gitting

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Mrs E. Keating 2202 Allendale Rd.

15

Filed

Robert P. Harrison

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 19 22

17

I HEREBY CERTIFY, That I attended deceased from

9-26, 1922, to 9/30, 1922.that I last saw him alive on 9/29, 1922.and that death occurred, on the date stated above, at 2.00 P.m.

The CAUSE OF DEATH* was as follows:

General carcinoma of the(duration) yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. 3 mos. 6 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of about 2 1/2 yrs.Was there an autopsy? noWhat test confirmed diagnosis? Microscopic(Signed) Dr. Bernard Weiss, M. D.1922 (Address) 914 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

Holy Redeemer
Robt & TurnerADDRESS 1442

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

10.68022 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68022

CERTIFICATE OF DEATH. 29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S Fremont ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Drapner

(a) RESIDENCE NO. 330 S. Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 19 ds. How long in U. S., if of foreign birth? 2 yrs. 11 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Oct 20, 1919

7 AGE Years 2 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Ind (State or country)

10 NAME OF FATHER George Drapner

11 BIRTHPLACE OF FATHER (city or town) Masegen (State or country) Suscacherienland

12 MAIDEN NAME OF MOTHER Mary Barraga

13 BIRTHPLACE OF MOTHER (city or town) Salestoa (State or country) Norway

PARENTS

14 Informant George Drapner (Address) 330 S. Fremont Balto

15

Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 9, 1922 to Oct 1, 1922, that I last saw him alive on Oct 1, 1922, and that death occurred on the date stated above, at

The CAUSE OF DEATH was as follows:

Infant (duration) no yrs. 11 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) R. J. [Signature] M. D.

(Address) 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mt Olivet

DATE OF BURIAL

Oct 2 1921

20 UNDERTAKER

and W. J. Tickner sons ADDRESS north and p. ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D 68023

33023

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Washington Ave* ST.: *27* WARD)2-FULL NAME *Samuel Francis Starr*(a) RESIDENCE. NO. *Washington Ave* ST.: *27* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *65* yrs.

mos.

ds.

How long in U.S., if of foreign birth? *68* yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*male white married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Catherine Starr*6 DATE OF BIRTH (month, day, and year) *Apr 20, 1852*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70 0 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15 Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 30* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Aug 23*, 19*22*, to *Sept 30*, 19*22*, that I last saw him alive on *Sept 30*, 19*22*, and that death occurred, on the date stated above, at *12:30 p.m.* The CAUSE OF DEATH* was as follows:*Chronic Tuberculosis* (duration) *3* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *not known*Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*What test confirmed diagnosis? *Examination of Sputum*(Signed) *William J. Hadd*

M. D.

19

(Address) *Washington Baltimore*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Gervais Rd. 3 19*22*

20 UNDERTAKER

ADDRESS

*Charles W. Conklin 924 E. Eager St.*MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68024

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68024

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *400 N. Fulton Ave* ST.; *16* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mrs Annie C. Wiegman*(Residence in Baltimore: No. *Home for the Aged of the U.E. Church* St.; *50* yrs. *50* mos. *50* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Widow*6-DATE OF BIRTH, *Aug 14, 1844*

(Month)

(Day)

(Year)

7-AGE, *78*yrs. *1* mos. *16* ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), *Germany. In U.S. Since 1872*10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER

(State or Country), *Unknown*12-MAIDEN NAME OF MOTHER *Marcie Wolburg-*

13-BIRTHPLACE OF MOTHER

(State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Helene E. Bennett*(Address) *400 N. Fulton Ave*

15-

Filed *Robert P. Harrison*

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 1, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 29, 1922*, to *Oct 1, 1922*,that I saw him alive on *Oct 1, 1922*,and that death occurred, on the date stated above, at *5 p.* m.

The CAUSE OF DEATH* was as follows:

Apoplexy.(Duration) *3* yrs. *3* mos. *3* ds.CONTRIBUTORY (Secondary) *Arterio Sclerosis.*(Duration) *2* yrs. *4* mos. *4* ds.(Signed) *George B. Shannon* M. D.*Oct 26, 1922* (Address) *700 Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death...yrs...mos...ds. In the State...yrs...mos...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *W. Olivet Cemetery*DATE OF BURIAL, *Oct 3, 1922*20-UNDERTAKER *George J. Smith*ADDRESS *Fayette St*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

102-1922

Burial Permit Clerk.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68025

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68025

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1911 Hollens St ST., 20 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent De Paul Beavans

(a) RESIDENCE NO. 1911 Hollens St ST., 20 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29 1921

7 AGE Years 1 Months 8 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER Raymond Beavans

11 BIRTHPLACE OF FATHER (city or town) DC
(State or country)

12 MAIDEN NAME OF MOTHER Helene McHenry

13 BIRTHPLACE OF MOTHER (city or town) DC
(State or country)

14 Informant Raymond Beavans
(Address) 1911 Hollens St

15 Robert P. Harris
Filed 19 20 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 19 22

17 HEREBY CERTIFY, That I attended deceased from Sept 28, 19 22, to Oct 1, 19 22, that I last saw him alive on Oct 1, 19 22, and that death occurred, on the date stated above, at 8.9 m.

The CAUSE OF DEATH* was as follows:
Pertussis

CONTRIBUTORY Brachio-pneumonia
(Secondary) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical
(Signed) Edw. E. Coolahan, M. D.
10/2/22 (Address) 24 N. Tilton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Cathedral Cn DATE OF BURIAL 10/3/22

20 UNDERTAKER Geo. A. Harley ADDRESS 1800 N. Fayette St.

OCT 2 1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68026

D 68026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 Patterson Westpat. WARD)

2-FULL NAME

Robert R. Reline

(a) RESIDENCE. No.

203 Patterson Westpat. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced (write the word)Infant5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofInfant

6 DATE OF BIRTH (month, day, and year)

April 10 1921

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.11021

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workInfant(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)md.

10 NAME OF FATHER

Bryant Reline11 BIRTHPLACE OF FATHER (city or town)
(State or country)md.

12 MAIDEN NAME OF MOTHER

Pydian Wholes13 BIRTHPLACE OF MOTHER (city or town)
(State or country)md.

14

Informant
(Address)Bryant Reline
Westpat.

15

File

Robert F. Harrison

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 1 1922

17

HEREBY CERTIFY, That I attended deceased from
Oct 1, 1922, to Oct 1, 1922,that I last saw him alive on Oct 1, 1922,
and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

DisruptedCONTRIBUTORY
(Secondary)(duration) no yrs. no mos. 2 ds.(duration) no yrs. no mos. 2 ds.18 Where was disease contracted
if not at place of deathyes

Did an operation pro

no

Date of

Was there an

no

What

diagnosis

EruptionmeaslesLupulandthe Disease Causing Death, or in deaths from Violent Causes,
(1) Means and Nature of Injury, and (2) whether Accidental,
or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery

DATE OF BURIAL

Oct 3 1922

20 UNDERTAKER

E. Schuman & Son

ADDRESS

1087

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

OCT 2 - 1922

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68027

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D 68027

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2527 Eastern Ave ST. WARD)

2. FULL NAME Labin George Kapp

(a) RESIDENCE NO. 2527 Eastern Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? 60 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Agatha Kapp (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-1835

7 AGE 87 Years Months 3 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Rea-Port Ship Gunner

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant W. H. Bense (Address) 2527 Eastern Ave

15 Filed Robert E. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1922, to Sept 30, 1922, that I last saw him alive on Sept 30, 1922.

and that death occurred, on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. L. Fox, M. D.

(Address) 7701 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

First German United Evangelical DATE OF BURIAL Oct 3rd 22

20 UNDERTAKER

Mrs C. Miller ADDRESS 2339 Jefferson

MARGIN RESERVED FOR BINDING. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 68028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68028

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 Fillmore ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cordelia A. Schroeder

(a) RESIDENCE. NO. 1440 Fillmore ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifelong mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward J. Schroeder

6 DATE OF BIRTH (month, day, and year) Jan 12/1853

7 AGE Years 67 Months 8 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER John Brown

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Griffith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Cordelia A. Schroeder (Address) 1440 Fillmore

15 Filed 1922 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-30 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to September 30, 1922,

that I last saw her alive on September 28, 1922,

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Cancer, Carcinoma of right breast and left inguinal glands

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death? 70

Did an operation precede death? 70 Date of operation

Was there an autopsy? no

What test confirmed diagnosis? 70

(Signed) J. H. Harrison, M. D.

(Address) 1118 Gough St. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Louisa Park Oct 3 1922

20 UNDERTAKER ADDRESS

H. M. Cook H & G M

Burial Permit Clerk:

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68029

D 68029

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4314 Risterstown Rd. ST. 28 WARD)

2-FULL NAME

(Residence in Baltimore: No. 4314 Risterstown Rd. St. 28 yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE. White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)

6-DATE OF BIRTH. April 4, 1888 (Month) (Day) (Year)

7-AGE. 84 yrs. 5 mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. At Home (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country). Balto Md

10-NAME OF FATHER. Ben Davis

11-BIRTHPLACE OF FATHER (State or Country). Balto Co

12-MAIDEN NAME OF MOTHER Nancy Wines

13-BIRTHPLACE OF MOTHER (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie S. Hine

(Address) 4314 Risterstown Rd.

15-

Filed. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Oct 1st, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1921, to Oct 1st, 1922, that I saw her alive on Oct 1st, 1922, and that death occurred, on the date stated above, at 3:45 p. m. The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 2 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 5 yrs. 5 mos. ds.

(Signed) Samuel A. Beach M. D. (Address) 2231 St. Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Landon Park DATE OF BURIAL. Oct 4, 1922

20-UNDERTAKER. William Cook ADDRESS 502 E North

Spec.—6-9-19—H. P. Co.—1000 Bks.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1752 Hampstead ST. 9 WARD)

2-FULL NAME Addison Millard Statore

(a) RESIDENCE. No. 1752 Hampstead ST. 9 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4⁰ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1-1868

7 AGE Years 55 Months 10 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work ~~Printer~~ typesetter (b) General nature of industry, business, or establishment in which employed (or employer) Canall Co. (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

10 NAME OF FATHER Rufus Stoupe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Lavilla Mayfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md.

14 Informant (Address) 1752 Hampstead ST.

15 Filled 19 1922 Robert P. HAYFLEIGH, Registrar

16 DATE OF DEATH (month, day, and year) Oct. 2, 1922

17 HEREBY CERTIFY, That I attended deceased from Sept. 1, 1922, to Oct 2, 1922, that I last saw him alive on Oct 1, 1922, and that death occurred, on the date stated above, at 10 A. m. The CAUSE OF DEATH* was as follows: Mitral & Aortic regurgitations (duration) 2 yrs. mos. ds. CONTRIBUTORY (Secondary) not known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical (Signed) J. E. Brumback, M. D. 102 1922 Address 1531 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL Oaklawn Cemetery 10/4 1922

20 UNDERTAKER ADDRESS Wm Cooke 502 E North

D 68030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68030

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 1922

17 HEREBY CERTIFY, That I attended deceased from Sept. 1, 1922, to Oct 2, 1922, that I last saw him alive on Oct 1, 1922,

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic regurgitations

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) not known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical (Signed) J. E. Brumback, M. D. 102 1922 Address 1531 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oaklawn Cemetery

10/4 1922

20 UNDERTAKER

ADDRESS

Wm Cooke

502 E North

Robert P. HAYFLEIGH, Registrar

Burial Permit 41572

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68031

D 68031

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

In the rear of

Registered No. C.

City of BALTIMORE: (No. 105. W. Hughes St. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillie Wills. (C)

(Residence in Baltimore: No. 1010 N. Carey St. St.; yrs. 20 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced. (Write the word.)
Female. Colored. Single

6-DATE OF BIRTH, November 17th, 1901, 1.
(Month) (Day) (Year)

7-AGE, 20 yrs. 10 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Samuel Wills. (C)

11-BIRTHPLACE OF FATHER, (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Cecelia Contee. (C)

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cornelia Wills. (C) aunt.

(Address) 1019 N. Carey St.

15-OCT 3-1922

Filed 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Body found September 30th, 1922, 1922.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
struck by some blunt instrument.
Homicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Oct. 2nd, 1922. (Address) 1015 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn 10/3/22

20-UNDERTAKER, ADDRESS

Samuel W. Chase 1400 Mosher St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68032

CERTIFICATE OF DEATH.

31

D 68032

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 N. Stricker

ST.: 16 WARD)

2-FULL NAME (Mary E. McCabe

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 938 N. Stricker

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1904

7 AGE Years 18 Months 7 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Saml. McCabe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rozanna Subse

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Rozanna McCabe 938 N. Stricker

15 Filed 19 1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1922

17 I HEREBY CERTIFY That I attended deceased from Aug. 4, 1922, Sept. 30, 1922, that I last saw him alive on Sept. 30, 1922, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) 8 yrs. 8 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Exam. Sputum (Signed) John D. Quinn, M. D.

(Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68033

CERTIFICATE OF DEATH.

90 D 68033

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1843 Koroanagh ST.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1843 Koroanagh St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH.

1865
(Month) (Day) (Year)

7-AGE.

57 yrs., mos. ds.
If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cement

9-BIRTHPLACE, (State or Country).

Baltimore County

10-NAME OF FATHER.

Benjamin Mulligan

11-BIRTHPLACE OF FATHER (State or Country).

Baltimore County

12-MAIDEN NAME OF MOTHER.

Matilda Brown

13-BIRTHPLACE OF MOTHER (State or Country).

Baltimore County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Sallie Mulligan (wife)

(Address).

1843 Koroanagh St.

15-

Filed 10-13-1922

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Sept 30, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Sept 30, 1922.that I saw him alive on Sept 29, 1922, and that death occurred, on the date stated above, at 11:55 am.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease(Duration) 1 yrs., mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs., mos. ds.(Signed) J. L. Langhart, M. D.191... (Address) 1601 Pennsylvania

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs., mos. ds. In the State 1 yrs., mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

St. Luke's Church

DATE OF BURIAL.

Oct 3, 1922

20-UNDERTAKER

James H. Lewis

ADDRESS

1303

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68034

CERTIFICATE OF DEATH.

113

D 68034

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 820 S Belmord Ave. WARD)

2-FULL NAME

Aniela Topa

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 820 S Belmord Ave. WARD.

(Usual place of abode) Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27-1921

7 AGE Years 1 Months 3 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Yan Topa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Zofia Topa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Yan Topa (Address) 820 S Belmord Ave

15 Filed Oct 3-1922 REGISTRAR ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 27th 1922 to Oct 20 1922, that I last saw him alive on Oct 20 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Enteritis - colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical examination (Signed) E. W. M. Longmire M. D.

(Address) 177 Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St Stanislaus Church Oct 3 1922

20 UNDERTAKER ADDRESS Stephen P. Trachovsky 170 S. Howard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68035

CERTIFICATE OF DEATH.

D 68035

D 68035

1-PLACE OF DEATH

Womans Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Sarah (Sadie) Stricklin Gross

(a) RESIDENCE NO.

(Usual place of abode)

Hampstead Md.

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

20 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward W. Gross

6 DATE OF BIRTH (month, day, and year)

May 25, 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

4

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hampstead Maryland

10 NAME OF FATHER

John S. Stricklin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hampstead Maryland

12 MAIDEN NAME OF MOTHER

Anna Utz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hampstead Maryland

14

Informant (Address)

Edward W. Gross
Hampstead Md.

15

Filed

OCT 3 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 12, 1922, to Oct 2, 1922,

that I last saw her alive on Oct 2, 1922,

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

General peritonitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of Oct 2, 1922

Was there an autopsy? No

What test confirmed diagnosis?

Operation

(Signed) Norman E. Tannenbaum, M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Md

Oct 4, 1922

20 UNDERTAKER

ADDRESS

Weglicker Sons

North Pa

in about two weeks.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Diffuse Fibroid Tumor
of Stomach Uterus
Non-malignant*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68036

CERTIFICATE OF DEATH.

D 68036

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sister of the Poor* ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Alexander Brennan*

(a) RESIDENCE. NO. *Preston & Valley Hts.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *abt 70*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Philadelphia* (State or country) *Pa.*

10 NAME OF FATHER *Thomas Brennan*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Margaret Collins*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Sister Florence* (Address) *Preston & Valley Hts.*

15 Filed *OCT 3 - 1922* 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 1* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *no record*, 19*22*.

that I last saw him alive on *Oct 1*, 19*22*.

and that death occurred, on the date stated above, at *8:30* P. M.

The CAUSE OF DEATH* was as follows:

Val. Disease of heart

unknown (duration) yrs. mos. ds.

CONTRIBUTORY *Pulmonary congestion* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. A. Wama*, M. D.

1922 (Address) *1138 Valley St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral

Oct 3 1922

20 UNDERTAKER

ADDRESS

H. C. Wiedefeld 914 Greenmount Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

8-68037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 111-0028-68037

1-PLACE OF DEATH *Maryland General Hospital* REGISTERED NO. *68037*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. *111-0028* ST. *11* WARD)

2-FULL NAME *Cleveland D. Harrison*

(a) RESIDENCE. NO. *Northumberland Co. Virginia* ST. *11* WARD. *11*
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. *9* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of *Margaret L. Harrison* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 7 1884*

7 AGE Years *37* Months *11* Days *25* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work *Fisherman* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) *Northumberland Co Va* (State or country)

10 NAME OF FATHER *Daniel Harrison*

11 BIRTHPLACE OF FATHER (city or town) *Northumberland Co Va* (State or country)

12 MAIDEN NAME OF MOTHER *Elizabeth Self*

13 BIRTHPLACE OF MOTHER (city or town) *Northumberland Co Va* (State or country)

14 Informant *Margaret L. Harrison* (Address) *Northumberland Co Va*

15 Filed *OCT 3-1922* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 2 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 23 1922* to *Oct 2 1922* that I last saw him alive on *Oct 2 1922* and that death occurred, on the date stated above, at *1:45 P. M.* The CAUSE OF DEATH* was as follows:
Acute ulcer (Peptic)

CONTRIBUTOR (duration) yrs. mos. ds. *Acute Peritonitis (Gastric)* (Secondary) (duration) yrs. mos. ds. *12*

18 Where was disease contracted *at home* if not at place of death?

Did an operation precede death? *Yes* Date of *Sept 23 1922*

Was there an autopsy? *No*

What test confirmed diagnosis? *Operation* (Signature) *James H. Hubert* M. D.

19 (Address) *Md. General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Blackwells St. - Northumberland Co. Va* DATE OF BURIAL *Oct 3, 1922*

20 UNDERTAKER *John H. Denny* ADDRESS *DC & RR 715 Light St*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 68038 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68038

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2905 Edmonson Ave St. 20 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John C O'Connor

(Residence in Baltimore: No. 521 Ringwood St. yrs. 12 mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, <u>Male</u>	4-COLOR OR RACE, <u>White</u>	5-Single, Married, Widowed, or Divorced, <u>Married</u> (Write the word.)	16-DATE OF DEATH, <u>Sept</u> <u>28</u> , 19 <u>22</u> (Month) (Day) (Year)	
6-DATE OF BIRTH, <u>Aug</u> <u>29</u> , 18 <u>71</u> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <u>Inquest</u> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <u>Inquest</u> find that said deceased came to <u>his</u> death on the day stated above.	
7-AGE, <u>51</u> yrs. <u>11</u> mos. <u>29</u> ds. If LESS than 1 day,hrs. ormin.?			The CAUSE OF DEATH* was as follows: <u>Angina Pectoris</u> (Duration) <u>Sudden</u> yrs.mos.ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <u>Printer</u> (b) General nature of industry, business, or establishment in which employed (or employer), <u>Baldamer,</u>			CONTRIBUTORY (Secondary) (Duration)yrs.mos.ds. (Signed) <u>James M. Brewster</u> M. D. (Coroner) <u>Sept 28 1922</u> (Address) <u>700 E. Chase St</u>	
9-BIRTHPLACE, (State or Country), <u>Philadelphia</u>			State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS.	10-NAME OF FATHER, <u>John O'Connor</u>		18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death,yrs.mos.ds. In the State,yrs.mos.ds.	
	11-BIRTHPLACE OF FATHER, (State or Country), <u>Brooklyn N.Y.</u>		Where was disease contracted, if not at place of death?	
	12-MAIDEN NAME OF MOTHER, <u>Mary Deery</u>		Former or usual residence,	
	13-BIRTHPLACE OF MOTHER, (State or Country), <u>Phila. Pa.</u>		19-PLACE OF BURIAL OR REMOVAL, <u>Western Cemetery</u> DATE OF BURIAL, <u>Oct 3</u> , 19 <u>22</u>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>Mrs. Mollie Kelly</u> (Address) <u>2228 Ellsworth St. Phila. Pa.</u>			20-UNDERTAKER, <u>John F. Denny</u> ADDRESS <u>715 Light</u>	
15- Filed <u>OCT 3-1922</u> ROBERT R. KRAUTER, Registrar. Burial Permit <u>61</u>				

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~D-68039~~ 68039

CERTIFICATE OF DEATH.

162

D 68039

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 N. Hollingdale ST., WARD)

2-FULL NAME

Frederick W. Willhite

(a) RESIDENCE No.

1710 N. Hollingdale ST., WARD

(Usual place of abode)
Length of residence in city or town where death occurred

yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30/22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Earl Willhite

11 BIRTHPLACE OF FATHER (city or town) (State or country) Springfield Ill

12 MAIDEN NAME OF MOTHER Elizabeth Miller, 1922 (Address) 1211 St Patterson Park Ave

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill

14 Informant Earl Willhite (Address) 1710 N. Hollingdale

15 Filed OCT 3-1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922, to Oct 2, 1922.

that I last saw him alive on Oct. 1, 1922,

and that death occurred, on the date stated above, at 12:30 p.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 2 ds. CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Albert Z. Hesser, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Baltimore DATE OF BURIAL 10/3 1922

20 UNDERTAKER Philip J. Henry ADDRESS 2016

MARGIN RESERVED FOR BONDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OSCUPEA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

68040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 Archer ST., 21 WARD)

2-FULL NAME May Catherine Pinkney

(a) RESIDENCE NO. 631 Archer ST., 21 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fe 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 10th 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 4 23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balt., Md. (State or country)

10 NAME OF FATHER Geo. L. Pinkney

11 BIRTHPLACE OF FATHER (city or town) Chesapeake, Md. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Liggans

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Elizabeth Pinkney (Address) 631 Archer St.

15 Filed 3-1922 ROBERT H. KAROTEN Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15th 1922 to Oct. 3rd 1922, that I last saw her alive on Oct. 2nd 1922, and that death occurred, on the date stated above, at 6.30 A. m. The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Lane M. D.

10/3/22 (Address) 140 W. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Auburn Center

Oct 3 1922

20 UNDERTAKER

ADDRESS

Isaac L. Brown 108 W. Montgo

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *410 n Pine* ST. *17* WARD)

2-FULL NAME

Calvin E Hill

(a) RESIDENCE. NO.

410 n Pine

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 15-1921

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

1 8 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Charles Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Myrtle Canton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Myrtle Hill 410 n Pine St

15

Filed

OCT 3-1922

ROBERT K. KRAVITZ

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

9/30 1922

17

HEREBY CERTIFY, That I attended deceased from *Sept 22 1922* to *Sept 30 1922*

that I last saw him alive on *Sept 30 1922*

and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis over

(duration) yrs. mos. ds. *10*

CONTRIBUTORY *Otitis Media Suppur.*

(Secondary) (duration) yrs. mos. ds. *?*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *H. S. McLean* M. D.

(Address) *2008 Grand Hill Dr*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Ambrose Cem

Oct 3 1922

20 UNDERTAKER

ADDRESS

Anna G. G. G.

Biddle

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably such*, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*not epidemic, no
other infectious
disease.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68042 HEALTH DEPARTMENT—CITY OF BALTIMORE 68042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *17* Ward)

Registered No. C.....

2-FULL NAME *Sgt Lee Valentin*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *522 St Marys st.* St.; yrs. *23* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *col* 5-Single, Married, *Married*, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH. *Feb 22 1891*
(Month) (Day) (Year)

7-AGE. *31* yrs. *8* mos. *7* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). *Pa.*

PARENTS.
10-NAME OF FATHER. *Scott Lee*
11-BIRTHPLACE OF FATHER. (State or Country). *Pa.*
12-MAIDEN NAME OF MOTHER. *Roxie Valentin*
13-BIRTHPLACE OF MOTHER. (State or Country). *Pa.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) *Robert R. Knauter*
(Address) *816 Union Street*

15-
Filed *OCT 3-1922* 10: *ROBERT R. KNAUTER*
Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Sept 29 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *autopsy* (autopsy or inquiry.) thereon and from the evidence obtained by said *autopsy* (autopsy or inquiry.) and that said deceased came to *death* (death) on the day stated above.

The CAUSE OF DEATH* was as follows:
Septic Pneumonia caused by bullet wound.

CONTRIBUTORY (Secondary) *Shot by Jack Johnson*
(Duration) ... yrs. ... mos. ... ds.
(Signed) *W. G. ...* M. D.
(Coroner.)
90.3 1922 (Address) *117 W. Saratoga St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

20-UNDERTAKER. ADDRESS.

James ...

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Morrow Hospital* ST., *16* WARD)

2-FULL NAME *Nathaniel Marks*

(a) RESIDENCE NO. *none (unknown)* ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE Years *62* Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Merchant Seaman*

(b) General nature of industry, business, or establishment in which employed (or employer) *Merch Seaman*

(c) Name of employer _____

9 BIRTHPLACE (city or town) *unknown* (State or country)

10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (city or town) *unknown* (State or country)

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town) *unknown* (State or country)

14 Informant *Parents History* (Address)

15 Filed *Oct 3-1922* Registrar *QJY*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10-2-1922*

17 I HEREBY CERTIFY, That I attended deceased from *6/3*, 1922, to *10-2*, 1922,

that I last saw him alive on *10-1*, 1922,

and that death occurred, on the date stated above, at *1* a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) *2* yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) *Senility*

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? *No* Date of _____

Was there an autopsy? *No*

What test confirmed diagnosis? *Autopsy examination* (Signed) *P. E. Schools*, M. D.

10/2 1922 Address *Morrow Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-MOVAL

DATE OF BURIAL

Trinity Cemetery *10/3* 19 *22*

20 UNDERTAKER

ADDRESS *1127*

S. Johnson & Co. *E. Balto St*

D 68044 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68044
D 68044

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 Robert

ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert J. Washington

(Residence in Baltimore: No. 418 Robert

St.: yrs. mo. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

Cae

5-SINGLE,

married
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Nov 5, 1885
(Month) (Day) (Year)

7-AGE,

34 yrs. 10 mos. 22 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Chief Clerk

9-BIRTHPLACE,

(State or Country)

Baltimore

10-NAME OF FATHER

Robert Washington

11-BIRTHPLACE OF FATHER

(State or Country)

Md

12-MAIDEN NAME OF MOTHER

Sarah Smith

13-BIRTHPLACE OF MOTHER

(State or Country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Bessie Washington

(Address)

418 Robert

15-OCT 3-1922

ROBERT R. KRAUTER,

Filed

191

Bureau Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Sept 30, 1922
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

Sept 30, 1922, to Sept 30, 1922

that I saw him alive on Sept 30, 1922

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute indigestion

CONTRIBUTORY (Secondary)

(Signed) W. J. Coleman M. D.

Oct 1, 1922 (Address) 2039 Maple St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

Oct 3, 1922

20-UNDERTAKER

John H. Toadum

ADDRESS

142

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68045

CERTIFICATE OF DEATH.

D 68045

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. 1)

2-FULL NAME

(Residence in Baltimore: No. 1)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-SINGLE

MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).

9-BIRTHPLACE

(State or County).

10-NAME OF
FATHER.

11-BIRTHPLACE
OF FATHER

(State or Country).

12-MAIDEN NAME
OF MOTHER

13-BIRTHPLACE
OF MOTHER

(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

OCT 3-1922

ROBERT R. KRAUTER,

Filed.....

191.....

Bureau Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, that I took charge of the
remains described above, held an inquest
(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said inquest,
autopsy, or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns from
an automobile
accident

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signature)..... D.

(Coroner.)

1922 (Address) 7472 Rolando

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state the MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRAN-
SIENTS, OR RECENT RESIDENTS).

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

PLACE OF BURIAL OR REMOVAL

Laurel, Mass.

DATE OF BURIAL

Oct 5-1922

20-UNDERTAKER

Chas. J. Ganssow

ADDRESS

1187 Mt. Royal

9W

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Hks.

D 68046

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D 68046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 48 E. Heath St. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie L. Long

(a) RESIDENCE No. 48 E. Heath St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Long

6 DATE OF BIRTH (month, day, and year) Feb. 23 1840

7 AGE Years Months Days If LESS than 1 day, hrs or min. 82 7 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Wingate Parks

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Lillie Mc Namer

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. Ferguson (Address) 48 E. Heath St.

15 OCT 3 - 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1922 to Oct 2, 1922 that I last saw her alive on Oct 1, 1922 and that death occurred, on the date stated above, at 1:40 A. M. The CAUSE OF DEATH* was as follows: Apoplexy

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Intero-sclerosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) J. F. Ferguson, M. D.

100, 1922 (Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Olivet Cemetery

DATE OF BURIAL

10/4 1922

20 UNDERTAKER

J. F. Mc Gully

ADDRESS

130 E. Fort

Spec.—6-9-19—H. P. Co.—1000 Bks.

68047 HEALTH DEPARTMENT—CITY OF BALTIMORE 68047

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp.* ST. *10* WARD)

2-FULL NAME *Mrs. Marie E. Kailer*

(a) RESIDENCE. No. *1227 Valley* ST. *10* WARD *Eastmore*

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred *24* yrs. *1* mos. *13* ds. How long in U. S.; if of foreign birth? *Life* mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of *F. Leon Kailer* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug. 19 1898*

7 AGE Years *24* Months *1* Days *13* If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work *Housewife* (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *MD*

10 NAME OF FATHER *Henry F. Schaefer*

11 BIRTHPLACE OF FATHER (city or town) *Bermain* (State or country)

12 MAIDEN NAME OF MOTHER *Mary Cleer*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *MD*

14 Informant *M. F. Leon Kailer* (Address) *1227 Valley St*

15 Filed *OCT 3 1922* REGISTRAR *ROBERT R. KRAUTER* Burial Permit Clerk

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

16 DATE OF DEATH (month, day, and year) *Oct. 2 1922*

17 I HEREBY CERTIFY, That I attended deceased from *October 1, 1922* to *October 2, 1922* that I last saw her alive on *October 2, 1922* and that death occurred, on the date stated above, at *12 P* m. The CAUSE OF DEATH* was as follows: *Myocardial Insufficiency*

(duration) yrs. mos. ds.

CONTRIBUTORY *Hypertensive Toxemia Pregnancy* (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Did an operation precede death? Date of Was there an autopsy? What test confirmed diagnosis? (Signed) *Bernard M. Wenz* M. D. *Oct 3 1922* (Address) *914 E. Baltimore St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Holy Redeemer Cemetery* DATE OF BURIAL *Oct. 6 1922*

20 UNDERTAKER *Henry Wood, Son* ADDRESS *1301 E. Eager St*

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 4-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Howard A. Kelly Hospital* WARD)

2-FULL NAME *Dr. Charles O. Rice*

(a) RESIDENCE. No. *1418 Eutaw Place* St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Anna M. Rice*

6 DATE OF BIRTH (month, day, and year) *Nov 28 1858*

7 AGE Years *63* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Physician*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Darkeville* (State or country) *Berkey Co. W. Va.*

10 NAME OF FATHER *Samuel Rice*

11 BIRTHPLACE OF FATHER (city or town) *Penna* (State or country)

12 MAIDEN NAME OF MOTHER *Louisa Borden*

13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)

14 Informant *Anna M. Rice* (Address) *7674 Race St Denver Col*

15 Filed *3-19-22* 19 *ROBERT R. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 2 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct. 2 1922* to *Oct 2 1922*

that I last saw him alive on *Oct 2 1922* and that death occurred, on the date stated above, at *3:50 P. m.*

The CAUSE OF DEATH* was as follows: *Carcinoma Liver*

CONTRIBUTORY (Secondary) *Arteriosclerosis* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Sept 25, 1922*

Was there an autopsy? *Yes* at autopsy

What test confirmed diagnosis? *Exam. & microscopic* (Signed) *Arthur C. Richards*

10/2, 1922 (Address) *1418 Eutaw Place*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Denver Col.* DATE OF BURIAL *Oct 4 1922*

20 UNDERTAKER *Chas. G. Black* ADDRESS *742 W. North Ave.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

568049 HEALTH DEPARTMENT—CITY OF BALTIMORE 568049

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Augusta Harthausen*

(a) RESIDENCE, NO. *Glenburnie, Md.* ST. *4* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *41* yrs. mos. ds. How long in U. S., if of foreign birth? *41* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of *Fred. Harthausen* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July, 23, 1870.*

7 AGE Years *52* Months *2* Days *8* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER *Wm. Schreiber*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Emma*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *Ferdinand Harthausen Jr.* (Address) *Glenburnie, Md.*

15 *Oct 3-1922* *ROBERT A. KRAUTER* Registrar

Racial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 1, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept. 26*, 19*22*, to *October 1*, 19*22*, that I last saw him alive on *October 1*, 19*22*, and that death occurred, on the date stated above, at *3:40 P. m.*

The CAUSE OF DEATH* was as follows:

Cellulitis & Lymphangitis of Leg

(duration) yrs. mos. *14* ds.

CONTRIBUTORY (Secondary)

Diabetes mellitus-acidosis.

(duration) yrs. mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *ye* Date of *9/27/22*

Was there an autopsy? *no*

What test confirmed diagnosis? *Laboratory & Clinical findings*

(Signed) *Anthony V. Buchner* M. D.

, 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill Cemetery. *Oct. 4, 1922.*

20 UNDERTAKER

ADDRESS

Mrs. J. E. Evans & Sons. #1428 S. Charles St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 268050 76 Municipal Hospital ST. 90 WARD 2 68050)

2-FULL NAME William H. Wheeler

(a) RESIDENCE No. Municipal Hospital

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced, (write the word)

Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

77

--

--

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Pedler

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Thomas Wheeler

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Fallon

13 BIRTHPLACE OF MOTHER (city or town) Eastern Shore
(State or country) Maryland

14

Informant Hospital Records,

(Address) Municipal Hospital.

15

Filed

OCT 3-1922

ROBERT A. KRAUER Registrar

Racial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1 19 22

17

I HEREBY CERTIFY, That I attended deceased from
August 29, 19 22, to October 1, 19 22,
that I last saw him alive on October 1, 19 22,
and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY
(Secondary)

(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde Wheeler

M. D.

10/2/19 22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Baltimore Cem.

DATE OF BURIAL

Oct 3, 19 22

20 UNDERTAKER

B. W. Dill

ADDRESS 3109

Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Joseph's Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 24 WARD)

2-FULL NAME

Mary E. Branigan

(a) RESIDENCE. No.

102 Beverly

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph P. Branigan

6 DATE OF BIRTH (month, day, and year)

Unk

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

75

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Thomas Egan

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

Mary Collins 102 Beverly St.

15

Filed OCT 3 - 1922

ROBERT R. KAHLER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 23, 1922, to Oct. 1, 1922,

that I last saw him alive on Sept. 30, 1922,

and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

P.S. & S

(Signed) John G. Kruger, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem. Oct 4, 1922

20 UNDERTAKER

ADDRESS

Margaret E. Flynn 1422 Highland St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

868052 HEALTH DEPARTMENT—CITY OF BALTIMORE 868052

CERTIFICATE OF DEATH.

159-002

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1240 Glyndon av St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Elmer Thomas Neisser

(Residence in Baltimore: No. 1240 Glyndon av St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Oct 2, 1922 (Month) (Day) (Year)

7-AGE, yrs..... mos..... ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, none (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Balt City

10-NAME OF FATHER, Elmer Thomas Neisser

11-BIRTHPLACE OF FATHER, (State or Country), Balt City

12-MAIDEN NAME OF MOTHER, Mary Kimball

13-BIRTHPLACE OF MOTHER, (State or Country), Balt City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Elmer Thomas Neisser (Address)..... 1240 Glyndon av

15.

Filed

OCT 3 - 1922

HUBERT R. KRAUTER

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 2, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Paroxysmal Oval Family Planning Complicated (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)..... (Duration)..... yrs..... mos..... ds. (Signed)..... M. R. Hamilton, M. D. (Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Balto. Cem. Oct 7, 1922

20-UNDERTAKER, ADDRESS

Margaret G. Hyman 1400 Light St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 3 WARD)

2-FULL NAME

Frank Lewa

(a) RESIDENCE. No.

321 S. Eden

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male White Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Oct 17 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 year

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Cesare Lewa

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Letizia Bracciotto

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

Cesare Lewa 321 S. Eden St.

15

Filed

ROBERT A. KRAUTER,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 19, 1922, to Oct. 3, 1922, that I last saw him alive on Oct. 3, 1922, and that death occurred, on the date stated above, at 4.05 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

Chr. Otitis Media; Ac. Intest. Indigestion

(duration) yrs. mos. 2 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Isidore J. Levy, M. D.

19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Vincent

Oct 7 1922

20 UNDERTAKER

ADDRESS

Mendell Dippel

820 S. ...

1. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

3-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3906 1/2 Charles ST.: 12 WARD) 100-001

2-FULL NAME

Anna Marston Cowman(a) RESIDENCE. NO. 3906 1/2 Charles ST. 12 WARD. Resident

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. ? mos. ? ds.How long in U. S., if of foreign birth? 88 yrs. 1 mos. 4 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

August-29-1834

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8814

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Anne Arundel Co. Maryland

10 NAME OF FATHER

Samuel S. Cowman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

A. A. Co. Maryland

12 MAIDEN NAME OF MOTHER

Anna Lamoad

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Fredrick Co. Md

14

Informant (Address)

Mr. Norman H. Potts (nephew) 3906 1/2 Charles St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1922, to Oct 3, 1922that I last saw her alive on Oct 3, 1922and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Family

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical symptoms(Signed) Wm. Pearce M. D.

103, 1922 Address)

1-E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Friends Burying GroundOct 5 1922

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

109 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

68055 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1700 William* ST. *24* WARD *4*)

2-FULL NAME

Mary Marie Seltzer(a) RESIDENCE. No. *1700 William* ST. WARD *4*

(Usual place of abode)

WARD *4*

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 9, 1876

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

46, 5, 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Henry Hodes

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Francis Bella

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant

(Address)

Mr Seltzer 1700 William St

15

Filed

19

Oct 3-1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10. 1* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Sept 15*, 19*22*, to *Oct 1*, 19*22*that I last saw him alive on *10/1*, 19*22*and that death occurred, on the date stated above, at *7:40 a.m.*

The CAUSE OF DEATH* was as follows:

Uremia
(duration) yrs. mos. ds. *16*CONTRIBUTORY *Chronic Bright's*
(Secondary) *from history* (duration) yrs. mos. ds. *17*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. J. Furlong*, M. D.*10/1, 19* (Address) *102 E. North Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Cross Cem. *10/4/22*

20 UNDERTAKER

J. J. Fahy & Sons *Light St.*

10.68056 HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68056

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital.*ST.: *7*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles Bender.*(a) RESIDENCE. No. *8571 Luzerne*

(Usual place of abode)

ST.,

WARD.

Length of residence in city or town where death occurred *35* yrs.

mos.

ds. How long in U. S., if of foreign birth? *26* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Mary Bender*6 DATE OF BIRTH (month, day, and year) *Not known*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

" Self 080

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Bohemia

10 NAME OF FATHER

Joseph Bender

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

14

Informant (Address)

Mary Bender 8571 Luzerne

15

Filed

Robert P. Garrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *September 30* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *September 18*, 19 *22*, to *September 30*, 19 *22*, that I last saw him alive on *September 30*, 19 *22*, and that death occurred, on the date stated above, at *3.15 P.m.*

The CAUSE OF DEATH* was as follows:

1. *Chronic hyperemia*2. *Hypertrophy and Dilatation of Heart*3. *Coronary Sclerosis* 4) *Aortic Sclerosis*5) *Relative Mitral Sclerosis* (duration) yrs. *7* mos. ds.

CONTRIBUTORY (Secondary)

Death Correlation Dilatation(duration) yrs. *8* mos. ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Miss Bellman*, M. D., 19 (Address) *Hebrew Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Redeemer**Sept 4* 19 *22*

20 UNDERTAKER

ADDRESS

*Paul Crockett**1906 W. 44th*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 3

-1922

D 68057

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68057

CERTIFICATE OF DEATH.

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1840 Clifton Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Baby Bidle

(a) RESIDENCE NO.

1840 Clifton Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, 1 hr. 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

1840 Clifton Ave. Baltimore

10 NAME OF FATHER

John Henry Bidle

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Alice Elizabeth Spach

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

London, Eng.

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from 10-2, 19 22 to 10-2, 19 22.that I last saw her alive on 10-2, 19 22.and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Susanne R. Parsons, M. D.10-2, 1922 (Address) 1702 Westwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

Oct 3rd 19 22

20 UNDERTAKER

Union Funeral Home

ADDRESS

Every item of information should be stated EXACTLY. PHYSICIAN should state Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every case of injury or-
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68058

CERTIFICATE OF DEATH.

D 68058

1-PLACE OF DEATH *Robt Garrett Hosp*
CITY OF BALTIMORE: (No. *27 N. Carey* ST., *12* WARD)

REGISTERED NO. _____
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME *Annie Craig*

(a) RESIDENCE NO. *2640 Mace* ST., _____ WARD _____

(Usual place of abode)
Length of residence in city or town where death occurred *life* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed,
or Divorced, (write the word) *Single*

6 If married, widowed, or divorced
HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *July 1 1922*

7 AGE Years *3* Months *1* Days _____ If LESS than
1 day, _____ hrs. _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work _____

(b) General nature of industry,
business, or establishment in
which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town)
(State or country) *Ind*

10 NAME OF FATHER *John Craig*

11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Ind*

12 MAIDEN NAME OF MOTHER *Annie Watson*

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *Ind*

14 Informant *Annie Craig*
(Address) *2641 Mace St*

15 _____
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 2 1922*

17 I HEREBY CERTIFY, That I attended deceased from
Sept 18, 19*22*, to *Oct 2*, 19*22*,
that I last saw her alive on *Oct 2*, 19*22*,
and that death occurred, on the date stated above, at *9 A* m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) _____ yrs. *2* mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted
if not at place of death? *unknown*

Did an operation precede death? *no* Date of _____

Was there an autopsy? *no*

What test confirmed diagnosis? *Physical Exam*

(Signed) *J. W. Clark*, M. D.

10/2 1922 (Address) *27 N. Carey St*

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

St Marys Hump Oct 3 1922

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut

D 68059

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

9 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Gen

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced (write the word)

Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1896

7 AGE

Years

Months

Days

26

Oct 1

1

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Factory (clothing)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

John H. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Mrs. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Charles H. Burton
207 N. Arlington Ave

15

Filed

Robert F. Harrison,

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 23, 1922, to Oct 2, 1922,

that I last saw him alive on Oct 1, 1922,

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

City, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

OCT 3-1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68060

CERTIFICATE OF DEATH.

D 68060

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 S. Dallas

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give NAME instead of street and number.)

2-FULL NAME Weronika . Barczak

(a) RESIDENCE NO. 402 S. Dallas

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank . Barczak

6 DATE OF BIRTH (month, day, and year) Feb 10 1890

7 AGE Years 32 Months 7 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore MD. (State or country)

10 NAME OF FATHER Anthony . Piatkowski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Frank . Barczak

(Address) 402 S. Dallas St.

15 Robert P. Harrison,

Filed 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT. 1 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept 29, 19 22, to Oct. 1, 19 22, that I last saw him alive on Oct 1, 19 22, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Acute Cordic dilatation following aspiration of left Pleura

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Lyons, M. D.

Oct 3, 19 22 (Address) 801 E. Calumet

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA St. Stanislaw

Oct 4 19 22

20 UNDERTAKER

ADDRESS

John M. Weber

1803 Bank

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Pleurisy with effusion,
probably tubercular*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68961

CERTIFICATE OF DEATH.

D 68961

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 871 W. Lombard ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Walczak

(a) RESIDENCE NO.

871 W Lombard

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

10/1/22 12:00 P.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 1/2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

Joseph Walczak

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Eva H. Shore

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt

14

Informant (Address)

Joseph Walczak
871 W Lombard St

15

Filed

, 19

Municipal Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/3/22 19

17

I HEREBY CERTIFY, That I attended deceased from

10/1/22, 19, to 10/3/22, 19that I last saw him alive on 10/2/22, 19and that death occurred, on the date stated above, at 87 m.

The CAUSE OF DEATH* was as follows:

Promaturity
(6 1/2 mo.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Bernard Ferry

M. D.

10/3/22 Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Mary'sOct 4 1922

20 UNDERTAKER

ADDRESS

John M. Weber1803 Bank

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

H D 68062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68062

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 779 W. PrattST.: 21

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kelly(a) RESIDENCE. NO. 779 W. Pratt

(Usual place of abode)

ST.,

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Kelly6 DATE OF BIRTH (month, day, and year) Aug 12th 1846

7 AGE

76

Years

Months

Days

If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)10 NAME OF FATHER Don't Know11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)12 MAIDEN NAME OF MOTHER Mary Hahn13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14

Informant Anne Buchholz
(Address) 779 W. Pratt

15

Filed Robert E. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 1 192217 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922, to Oct 1, 1922, that I last saw him alive on Sept 30, 1922, and that death occurred, on the date stated above, at 3 P m.The CAUSE OF DEATH* was as follows: arterio sclerosis(duration) 3 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of ____Was there an autopsy? noWhat test confirmed diagnosis? Physical Exam(Signed) Kurt J. Hahn, M. D.3, 1922 (Address) 23 W. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore County Oct 4th 1922

20 UNDERTAKER

ADDRESS

Geo Lemback & Co 647 W. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68063

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68063

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Balton St. ST. 11 WARD)

2-FULL NAME

Petronella Williams

(a) RESIDENCE NO.

924 Balton St.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. - mos. - ds.(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed or divorced HUSBAND or (or) WIFE of

Clarence Williams

6 DATE OF BIRTH (month, day, and year)

1/10/1890

7 AGE

Years

Months

Days

328

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Victorine P. Augustus

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Idel Barges

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

Charles P. Augustus

15

Filed

Robert P. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/2/1922

17

I HEREBY CERTIFY, That I attended deceased from 9/20/1922 to 10/2/1922, that I last saw him alive on 9/30/1922, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia phthisis,(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) H. L. Jackson M. D., 19 (Address) 767-W-Annapolis

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Auburn Bur

20 UNDERTAKER

Daniel Easton

DATE OF BURIAL

OCT 4 1922

ADDRESS

916 Penna

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

73-1922

Burial Permit closed

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68064

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

ROBERT R. MAUTER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

9/12/22 19 to 10/2/22

that I last saw her alive on 10/2/22 19

and that death occurred, on the date stated above, at 8:05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular
endocarditisCONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS COR

CALHOUN

HOLLINS

PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68066

CERTIFICATE OF DEATH.

90 D 68066

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1250 St. Monroe St. ST. 15 WARD)

2. FULL NAME

Hannah Freedman

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

1250 St. Monroe St. ST. 15 WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 30 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

Jacob H. Freedman

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

88

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Abraham Judas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E. 14th St.

15

FED

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1922, to Oct. 3, 1922.that I last saw her alive on Oct. 2, 1922.and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Regurgitation, Diffuse Nephritis(duration) 2 yrs. mos. ds.CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Physical Signs(Signed) R. C. McNeill, M. D.Oct. 3 1922 (Address) 1903 W. 14th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Heaven Brook Road 1922

20 UNDERTAKER

Jack Lewis 1439 E. 14th St.

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Lee & Brightwell
HEALTH DEPARTMENT—CITY OF BALTIMORE
188-003

D 68067 D 68067

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. *26* St. *Ward*) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Lee G. Brightwell*
(Residence in Baltimore: No. *Camp Hobart* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5-Single, Married, Widowed, or Divorced, <i>Single</i> (Write the word.)	16-DATE OF DEATH, <i>Oct 2</i> (Month) (Day) (Year)	17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>inquest</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>inquest</i> (Inquest, autopsy or inquiry.) and that said deceased came to <i>death</i> on the day stated above. The CAUSE OF DEATH* was as follows: <i>Multiple Fractures</i> <i>Auto Accident</i> (Duration) yrs. mos. ds.
6-DATE OF BIRTH, <i>Unknown</i> (Month) (Day) (Year)	7-AGE, <i>22</i> yrs. <i>8</i> mos. ds.	If LESS than 1 day, hrs. or min.	CONTRIBUTORY (Secondary) <i>Shock</i> (Duration) yrs. mos. ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Private</i> (b) General nature of industry, business, or establishment in which employed (or employer), <i>Soldier</i>			(Signed) <i>Robert R. Krauter</i> M. D. (Coroner.) 192... (Address) <i>4316 E. Pratt</i>	
9-BIRTHPLACE, (State or Country), <i>Charlottesville VA</i>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS.	10-NAME OF FATHER, <i>Unknown</i>	11-BIRTHPLACE OF FATHER, (State or Country), <i>VA</i>	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.	
	12-MAIDEN NAME OF MOTHER, <i>Sarah E Brightwell</i>	13-BIRTHPLACE OF MOTHER, (State or Country), <i>VA</i>	Where was disease contracted, if not at place of death?	
	14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Camp</i> (Address) <i>Hobart Rd</i>		Former or usual residence	
	15- Filed <i>OCT 4-1922</i> <i>ROBERT R. KRAUTER</i> Registrar.		19-PLACE OF BURIAL OR REMOVAL, <i>Powicke VA</i> DATE OF BURIAL, <i>10-4</i> 19 <i>22</i>	
		20-UNDERTAKER, <i>Jack Lewis</i> ADDRESS <i>1439 E. Pratt</i>		

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1323 Mt. Royal Ave. St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1323 Mt. Royal Ave. St. 73 yrs. 5 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

female

4-COLOR OR RACE

white

5-Single, Married, Widowed, or Divorced.

married
(Write the word.)

6-DATE OF BIRTH

April 12, 1849
(Month) (Day) (Year)

7-AGE

73 yrs. 5 mos. 20 ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

9-BIRTHPLACE

(State or Country)

Balto. Md.

10-NAME OF FATHER

Dietrich Schmitt

11-BIRTHPLACE OF FATHER

(State or Country)

Germany

12-MAIDEN NAME OF MOTHER

Gubman

13-BIRTHPLACE OF MOTHER

(State or Country)

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Louis Grebb

(Address)

1323 Mt. Royal Ave.

15-

FIND

OCT 4 - 1922

ROBERT R. KRAUTER,

Sanitary Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 2, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. F. Hennessy M. D.

(Coroner)

Oct 13, 1922 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cem. Oct 4, 1922

20-UNDERTAKER

ADDRESS

Wm. J. Knerdon Notch Rd.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68969

D 68969

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Baltimore city*
CITY OF BALTIMORE: (No. *Montifelter* ST., *9* WARD)
2. FULL NAME *Blanche Ellen Montgomery*
(a) RESIDENCE NO. *none* ST., *none* WARD
(Usual place of abode)
Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. *46*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*
5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mr. F. Montgomery*
6 DATE OF BIRTH (month, day, and year) *Aug 28 1922*
7 AGE Years Months Days If LESS than 1 day, hrs or min. *53 5 20*

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *Household duties*
(b) General nature of industry, business, or establishment in which employed (or employer) *837*
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Larry, England*
10 NAME OF FATHER *Don't know*
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER *Don't know*
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Mr. F. Montgomery*
(Address) *Fallston, Md*

15 Filed *4-19-22* *ROBERT B. BAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 3 1922*
17 I HEREBY CERTIFY, That I attended deceased from *Aug 28 1922* to *Oct 3 1922*
that I last saw him alive on *Oct 2 1922*
and that death occurred, on the date stated above, at *12 noon* m.
The CAUSE OF DEATH* was as follows:
Exhaustion & Toxemia

(duration) yrs. mos. ds.
CONTRIBUTORY *Barium*
(Secondary) *Barium* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) *Clara J. Jones* M. D.
, 19 (Address) *4216 1st St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *Fallston Md* DATE OF BURIAL *Oct 4 1922*

20 UNDERTAKER *Wm. J. McKelvey* ADDRESS *North Pa*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68070

CERTIFICATE OF DEATH.

D 68070

D 68070

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *918 W. Pratt*)ST.: *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Fannie Rigg(a) RESIDENCE. No. *918 W. Pratt*

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs.

mos.

ds. How long in U. S., if of foreign birth? *30* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*Female white**Married*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Wife*

6 DATE OF BIRTH (month, day, and year)

June 7, 1862

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*60**3**25*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Phila Pa*

10 NAME OF FATHER

*John Dunbar*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Phila Pa*

12 MAIDEN NAME OF MOTHER

*Sentiment*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Phila Pa*

14

Informant

(Address)

*Linnae Rigg
918 W Pratt St*

15

Filed

Oct 4-1922

ROBERT H. HANCOCK

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct-2* 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 13, 1922, to *Oct. 2*, 1922,that I last saw him alive on *Oct. 1*, 1922,and that death occurred, on the date stated above, at *7:30 P.* m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia(duration) yrs. *6* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?*Yes*

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

Monley Hoag

M. D.

104, 1922

(Address)

729 Wash. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western**Oct 5* 19

20 UNDERTAKER

ADDRESS

Le. J. Fields 1200 W Lombard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68071

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 318 4 Cary St. 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.. Duncan H. Crossley

(Residence in Baltimore: No. 318 4 Cary St.; yrs. 13 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Oct 20 1887 (Month) (Day) (Year)

7-AGE, 24 yrs. 11 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Clerk (b) General nature of industry, business, or establishment in which employed (or employer), US Post office

9-BIRTHPLACE, (State or Country), Philadelphia

10-NAME OF FATHER, Clifford H. Crossley

11-BIRTHPLACE OF FATHER, (State or Country), Philadelphia

12-MAIDEN NAME OF MOTHER, Adalaid Walling

13-BIRTHPLACE OF MOTHER, (State or Country), Philadelphia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Frank S. Crossley

(Address), 1320 W Lexington

15- 2761-8120 REGISTRAR

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 3 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Bullet wound through heart in side (Duration) 24 hrs. ds.

CONTRIBUTORY (Secondary) mental depression (Duration) 1 yrs. mos. ds. (Signed) James H. Sauton M. D. (Coroner.) (Address) 750 E. Charles

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, Oct 5 1922

20-UNDERTAKER, John O. Mitchell ADDRESS, 1201 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE
2-FULL NAME Peter B. Fitzpatrick
(Residence in Baltimore: No. 213 E. Heath St.)
REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
74-001
WARD
Lifeline

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
6-DATE OF BIRTH Unknown, 1862
7-AGE, 60 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE (State or Country).
10-NAME OF FATHER.
11-BIRTHPLACE OF FATHER (State or Country).
12-MAIDEN NAME OF MOTHER.
13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph McKewen
(Address) 213 E. Heath St.

15-
Filed OCT 4-1922
ROBERT R. KRAUTER
Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 2, 1922
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the date stated above.
The CAUSE OF DEATH* was as follows:
apoplexy
(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary) ... yrs. ... mos. ... ds.
(Signed) J. H. Morrison M. D. (Coroner)
(Address) 3832 Roland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, Rethel Cemetery
DATE OF BURIAL, Oct 5, 1922

20-UNDERTAKER, Elias Evans
ADDRESS, 1100 N. Royal Ave

D 68073 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4311 Ready Ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Sichel

(a) RESIDENCE. No. 4311 Ready Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female white widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Louis D. Sichel

6 DATE OF BIRTH (month, day, and year) May 28 1849

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
73 4 04

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md
(State or country)

10 NAME OF FATHER John Philip Orth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schwartz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany14 Informant Annie Sichel
(Address) 4311 Ready Ave

15 Filed 1922 H.A.M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 1922

17 I HEREBY CERTIFY, That I attended deceased from

May 1, 1921, to Oct. 2, 1922,

that I last saw her alive on Oct. 1, 1922,

and that death occurred, on the date stated above, at 3-15 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

CONTRIBUTORY (duration) 3 yrs. mos. ds.
Chrom. interstitial Nephritis
(Secondary) (duration) 3 yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H.C. Hesse, M. D.

10-2, 1922 (Address) 5600 York Rd. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Oct. 4, 1922

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68074

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. 9 ST., 9 WARD)

2-FULL NAME

Mary Gregory

(a) RESIDENCE NO.

1505 Lamont

(Usual place of abode)

ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

18 5 3

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Willsomson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Do

12 MAIDEN NAME OF MOTHER

Do

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Bayview Hospital Baltimore, Md.

15

Filed

19

H. A. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 1, 1922

17

I HEREBY CERTIFY that I attended deceased from

Dec. 2, 1920, to Oct 1, 1922

that I last saw him alive on Sept. 30, 1922

and that death occurred, on the date stated above, at 10:09 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Breast

CONTRIBUTORY

(Secondary)

Anemia

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical findings

(Signed)

H. A. H. M. D.

(Address)

Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

St. Patrick's Cemetery Oct 5, 1922

20 UNDERTAKER

ADDRESS

J. A. Moran E. Ball

D 68075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *md Gen Hosp 27* ST. *27* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *10 E Virginia St* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Earl Kirby*6 DATE OF BIRTH (month, day, and year) *June 18 - 1897*

7 AGE Years Months Days

24

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *H. N.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *City*10 NAME OF FATHER *Earnest W. Horvath*11 BIRTHPLACE OF FATHER (city or town) (State or country) *German*12 MAIDEN NAME OF MOTHER *Marie Loeffler*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *German*

14

Informant (Address) *Earl Kirby 10 E Virginia St*

15

Filed *1922* 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/2/22*

17

I HEREBY CERTIFY, That I attended deceased from *9/16/22* 19 to *10/2/22* 19that I last saw him alive on *10/2/22* 19and that death occurred, on the date stated above, at *10.25* m.

The CAUSE OF DEATH* was as follows:

Intestinal myxoid

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *Chemical Symp.*(Signed) *I no assumption* M. D., 19 (Address) *md Gen Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Int. Obit. Home**Oct 4 1922*

20 UNDERTAKER

ADDRESS *300**E. Q. Moran**E. Bell*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68076

68076

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *845 Linden Ave* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *845 Linden Ave* ST. *11* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *C* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years *50* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va.*10 NAME OF FATHER *Alonzo Jordan*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va.*12 MAIDEN NAME OF MOTHER *Jane Hunsford*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va.*14 Informant *Frances Vessels* (Address) *845 Linden Ave*15 Filed *10/3/22* 19 *22* Registrar *H.A.M.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 2* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *Aug 29* 19 *22* to *Oct 2* 19 *22*, that I last saw him alive on *Oct 1* 19 *22*, and that death occurred, on the date stated above, at *9 P.* m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis
(duration) yrs. *10 1/2* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *H.S. McLeod* M. D. *10/3, 1922* Address *2008 Druid Hill Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

W. Auburn Ametay *Oct 4* 19 *22*
20 UNDERTAKER ADDRESS *Robert E. McLeod 1106 Chatham*

Physicians should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68077

CERTIFICATE OF DEATH.

44 ✓ D 68077

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie V. Gayhardt.

(a) RESIDENCE No. 1158 Carroll St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married.

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

George Gayhardt.

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

37

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Wm. Baker

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Dolly Jones

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country)

Md.

14

Informant George Gayhardt.

(Address) 1158 Carroll St.

OCT 4 1922

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1922, to Oct. 2, 1922.

that I last saw her alive on " " 1922

and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 2 mos. ds.

CONTRIBUTORY Auto-intoxication

(Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolehan, M. D.

10/19 22 Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Olivet Cemetery

Oct 5 1922

20 UNDERTAKER

ADDRESS

James Dignan & Son

1000 Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68078

CERTIFICATE OF DEATH.

D 68078

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Eden ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson(a) RESIDENCE NO. 103 N. Eden ST., 5 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Simon Johnson6 DATE OF BIRTH (month, day, and year) July 2 / 18747 AGE Years 51 Months 4 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)10 NAME OF FATHER James Douglas11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)12 MAIDEN NAME OF MOTHER Elizabeth Douglas13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)14 Informant Donald Johnson (Address) 103 N. Eden St.15 Filed 4-19-22 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 / 192217 I HEREBY CERTIFY, That I attended deceased from May 2 / 1922, to Oct 2 / 1922, that I last saw him alive on Oct 1 / 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not knownDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? none(Signed) Richard J. Eslinger, M. D.19 PLACE OF BURIAL, CREMATION OR RE-
MAYAL Mt. Airline Cem

DATE OF BURIAL

Oct 3- 1922

20 UNDERTAKER

Mrs Robert A. ElliottADDRESS 1725-Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D-68979 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68979

CERTIFICATE OF DEATH. 16-003

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Harry White(a) RESIDENCE No. 6034 Central Ave. City

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

HUSBAND ofWIFE of Bessie White (mother)6 DATE OF BIRTH (month, day, and year) Dec. 17, 19217 AGE Years 1 Months 9 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child(b) General nature of industry, business, or establishment in which employed (or employer) 47(c) Name of employer 479 BIRTHPLACE (city or town) Balto. (State or country) Maryland10 NAME OF FATHER Harry Cornish11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland12 MAIDEN NAME OF MOTHER Bessie White13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland14 Informant JOHNS HOPKINS HOSPITAL (Address) Records15 Filed 1-1-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 19, 1922, to Oct 3, 1922.that I last saw him alive on Oct 3, 1922.and that death occurred, on the date stated above, at 12:05 A.M.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner type)(duration) yrs. mos. 18 ds.CONTRIBUTORY The same (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted At home if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Blood agglutination(Signed) A. F. Welch, M. D., 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Auburn Cemetery DATE OF BURIAL Oct 4 192220 UNDERTAKER Mrs Robert A. Elliot ADDRESS 1725-1725Oakland Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68080

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

WARD

2-FULL NAME

(a) RESIDENCE No.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 9/30, 1922, to 10/2, 1922.

that I last saw her alive on 10/2, 1922, and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Vital Regurgitation
Chronic Nephritis
several
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

arterio-sclerosis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (Diet & exercise)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Henry Russell, M. D.

, 19 (Address) 3902 Greenland St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68081

CERTIFICATE OF DEATH.

D 68081

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 Pleasant ST., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

ROBERT R. KRAUTER,

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 24, 1922, to Oct. 4, 1922

that I last saw him alive on Oct 3, 1922

and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Stomach

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. J. Simpson, M. D.

, 19 (Address) 1340 Chesapeake

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mt. Carmel

20 UNDERTAKER

E. J. Johnson

DATE OF BURIAL

Oct 6, 1922

ADDRESS

4. B. D. M.

D 68083

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68083

CERTIFICATE OF DEATH.

99-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Baker ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Elizabeth Sutherland

(a) RESIDENCE NO.

1628 Baker

ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

—

6 DATE OF BIRTH (month, day, and year)

Feb 13 / 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Frederic B. Sutherland

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balt

12 MAIDEN NAME OF MOTHER

Gertrude Tremble

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balt.

14

Informant

(Address)

Gertrude Sutherland
1628 Baker St

15

Filed

4-1922ROBERT R. KRAUTERBurial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

July, 1922, to Oct 3, 1922.that I last saw him alive on Oct 3, 1922.and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchitisover

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

HomeDid an operation precede death? no Date of ✓Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Levin M. Eastman Jr.

M. D.

14, 1922

(Address)

1505 Edmundson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral CemeteryOct 5 1922

20 UNDERTAKER

ADDRESS

Frank A. Fink915 E. Bay

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Acute

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68084

CERTIFICATE OF DEATH.

31 D 68084

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)2-FULL NAME Dorothy Stanley

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 310 Myrtle ave.ST. WARD(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 19207 AGE Years Months Days If LESS than 1 day, hrs. or min.
2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland10 NAME OF FATHER Howard Stanley11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Reba Brown13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Hospital records
(Address) M. T. H.15 ROBERT H. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 2, 192217 I HEREBY CERTIFY, That I attended deceased from
Nov. 10, 19 21, to Oct. 2, 1922.that I last saw her alive on Oct. 2, 1922.and that death occurred, on the date stated above, at 9.05 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Mastoiditis(duration) 1 yrs. 6 mos. over ds.CONTRIBUTORY Suppurative adenitis
(Secondary)(duration) 9 yrs. 9 mos. 9 ds.18 Where was disease contracted Unknown
if not at place of death?Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Padaghiacca M. D.10-3-22 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Lesbury CemOct 5 1922

20 UNDERTAKER

ADDRESS

Mrs. J. G. Locke 1302 Jefferson

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state EXACTLY, AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Reported as tuberculosis
in Nursing Division.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Marshall, ST. 73 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Dorothy A Kroth

(a) RESIDENCE NO.

1706 Marshall

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 6 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 8, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

John J. Kroth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Beatha Shubert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Beatha Kroth (Mother)
1706 Marshall St

15

Signed

Robert E. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 4, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1922 to Oct 4, 1922that I last saw him alive on Oct 4, 1922and that death occurred, on the date stated above, at 455 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) R E Harrison M.D.(Address) 1644 Sunnyside

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill Cem

DATE OF BURIAL

10-6-22

20 UNDERTAKER

E & B Hart 1156 West 8th

ADDRESS

1. Write plainly, with unobscured ink. This is a permanent record. It should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

74-1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68086

CERTIFICATE OF DEATH.

D. 68086

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Bentalon ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Flora P. Green

(a) RESIDENCE NO. 111 N. Bentalon ST., 20 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 7 mos. X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married Widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Frank W. Green

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 62 11 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

X

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Upper Fairmount,
Maryland.

10 NAME OF FATHER

Wm. E. Ford

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Muir

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

(Address)

W. J. Green
1602 Halling Ave.

15

led

Robert E. Barry

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 3 1922, to Oct. 4 1922.

that I last saw her alive on Oct. 4 1922.

and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows: Patient had
a cerebral hemorrhage in 1917 or
1918 followed by right sided hemiplegia
attacks like epileptiform spasms some
at long intervals, the last one coming
yesterday a.m. and not ceasing
death coming as noted.

CONTRIBUTORY (Secondary) death coming as noted.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) O. J. Hoffmann M.D.

, 19 (Address) 3402 Halbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

West Over in

DATE OF BURIAL

10/5 1922

20 UNDERTAKER

Robert. Brooks & Son

ADDRESS

Calhoun
Hollins st

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68087

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1609 / Hammer ST.: 23 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1609 / Hammer ST., WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 11 / 1876

7 AGE Years 46 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

Robert E. Hall

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan - 1 1922, to Oct - 2 1922,

that I last saw her alive on Oct. 2 1922,

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Cor pulmonale. Tuberc. from breast, with metastases to brain and orbit.

(Primary 1 yr.) (duration) 1 yrs. - mos. - ds.

CONTRIBUTORY (Secondary)

(duration) - yrs. 6 mos. - ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. W. Calkins

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

4-1922

Burial Permit's Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68088

D 68088

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1100 W. Lombard* ST., *18* WARD)

2. FULL NAME

William A Klose

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1100 W. Lombard

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

May - 7 - 1885

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*37**7**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

Ship Building

(c) Name of employer

Union Ship Building Co.

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Anthony Klose

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Theresa Kueger

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Maryland

14

Informant

Joseph W. Klose

(Address)

900 N. North An.

15

Filed

Robert E. HARRISON

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Oct 1st 1922, to Oct 4th 1922*that I last saw him alive on *Oct 3rd 1922*and that death occurred, on the date stated above, at *6 17 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Alcoholism

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of —Was there an autopsy? *no*What test confirmed diagnosis? *Physical signs etc*

(Signed)

J. H. Robertson, M. D.

10/4, 19

(Address) *888 W. Lombard St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

Oct 6 1922

20 UNDERTAKER

*Harry W. Ehlen*ADDRESS *1944**W. North An*

N. B. — WRITE PLAINLY, WITH UNFADING INK. THIS IS A STATISTICAL RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

4-1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68089

CERTIFICATE OF DEATH.

8 68089

D 68089

X 123

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. U. P. I. ST. 14 WARD)

2. FULL NAME

Dr. George R. Burgess

(a) RESIDENCE NO.

Wayne, W. Va.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mrs. J. T. Burgess

6 DATE OF BIRTH (month, day, and year) 10-20-1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

11

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Boys, Kentucky

10 NAME OF FATHER

Geo. R. Burgess

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Kentucky

12 MAIDEN NAME OF MOTHER

Spurlock

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

W. Va.

14

Informant (Address)

Wesley S. Burgess
631 14th St. Huntington W. Va.

15

Filed

OCT 5-1922

HUBERT R. KAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1922, to October, 1922, that I last saw him alive on October, 1922, and that death occurred, on the date stated above, at 1302 m.

The CAUSE OF DEATH* was as follows:

cholelithiasis & ungovernable
strains of bile following
operation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept. 9, 1922

Was there an autopsy? no

What test confirmed diagnosis? operation

(Signed) P. B. Price, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Wayne W. Va

DATE OF BURIAL

Oct 5 1922

20 DEFTAKER

John O. Mitchell

ADDRESS

1201 W. Fayette

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 10-2-1922, to 10-2-1922,

that I last saw ~~her~~ alive on 10-2-1922,

and that death occurred, on the date stated above, at 8:15 p.m.

The CAUSE OF DEATH* was as follows:

Brain Abscess - over

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Cause state (1) Means and Nature of Injury, and (2) Cause of Death, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

ROBERT R. KRAUTER Registrar

Permit Clerk

Physicians should state EXACTLY. Exact statement of OCCASION. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCASION. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

no further history.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 68091

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 68091

CERTIFICATE OF DEATH

1-PLACE OF DEATH *On board ship Jack boat Grayson*
City of BALTIMORE: No. *Foot of Broadway* Ward (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *John T. Leddor*
(Residence in Baltimore: No. *on board boat Grayson* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male*
4-COLOR OR RACE, *white*
5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*
6-DATE OF BIRTH, *Unknown*
7-AGE, *about 70* yrs., mos., ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Junk dealer*
(b) General nature of industry, business, or establishment in which employed (or employer) *886*
9-BIRTHPLACE, (State or Country), *Balto. Md*
10-NAME OF FATHER, *Geo. Leddor*
11-BIRTHPLACE OF FATHER, (State or Country), *New York, N.Y.*
12-MAIDEN NAME OF MOTHER, *Sarah M. Hall*
13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. B. Leddor*
(Address) *1262 E. North Ave*

15-

FILED

OCT 5 - 1922

ROBERT R. MAUTER,
Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, *Oct 2nd* 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Autopsy* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Autopsy* and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain

CONTRIBUTORY (Secondary)

Fractured Skull supposed to have been inflicted by murder
(Signed) *Thos. B. Horton* M. D.
(Coroner)

Oct 4 - 1922 (Address) *Curtis Bay, Balto.*

*State the Disease Causing Death, or, in deaths from violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Balto. Cemetery *10/5/* 1922

20-UNDERTAKER, ADDRESS
Mrs Cook, 502 E North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 68092

CERTIFICATE OF DEATH.

123

D 68092

1-PLACE OF DEATH *Church Home & Inf.*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *146 N. Broadway* ST., *24* WARD)

2-FULL NAME *Mrs. Lorraine Dickinson*

(a) RESIDENCE No. *1313 Light St*

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Joseph Dickinson

6 DATE OF BIRTH (month, day, and year) *Feb. 14, 1860*

7 AGE Years *62* Months *10* Days *11* LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

037

(c) Name of employer

9 BIRTHPLACE (city or town) *Del.* (State or country)

10 NAME OF FATHER *John Meredith*

11 BIRTHPLACE OF FATHER (city or town) *Del.* (State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Del.* (State or country)

14 Informant *Mrs. Clara D. Douglass* (Address) *1313 Light St*

15 *1015-1922* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 3 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 28 1922*, to *Oct 3 1922*, that I last saw her alive on *Oct 3 1922*, and that death occurred, on the date stated above, at *11 00 P. m.*

The CAUSE OF DEATH* was as follows: *Acute dilatation heart*

CONTRIBUTORY (Secondary) *Cholelithiasis* (duration) yrs. mos. ds. *1/2* *Cholelithiasis* (duration) yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Oct 2 1922*

Was there an autopsy? *No*

What test confirmed diagnosis? *Operation & Microscopic* (Signed) *Richard G. Roberts, M. D.*

19 (Address) *Church Home & Inf.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Linden Park Cemetery DATE OF BURIAL *Oct 7 1922*

20 UNDERTAKER ADDRESS

F. H. France & Son *703 Hanover St*

E 68093

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 68093

1-PLACE OF DEATH

University Hospital

CERTIFICATE OF DEATH.

REGISTERED NO.

183

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lewis E. Smith

(a) RESIDENCE. NO.

Monkton Rd.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Lewis Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Julia Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

15

File 15-1022

ROBERT P. KRAUTER

Registrar

(over)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Aug 25 1924

17

I HEREBY CERTIFY, That I attended deceased from

Aug 20, 1924, to Aug 25, 1924,

that I last saw him alive on Aug 25, 1924,

and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute suppurative appendicitis
General peritonitis
Dissecting aortic aneurysm

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial infarction

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of Aug 20, 1924

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Hovine M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Vernon E. Cemetery

Aug 29 1924

20 UNDERTAKER

ADDRESS

P. Marklinson

White Hall

Phillip Marklin & Son

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 68094 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *John Hopkins Hosp.* ST.: *V* WARD)

2-FULL NAME *Elisrael Tobackman*

(Residence in Baltimore: No. *6 S. Ann street*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

10 St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH, *Unknown*, 1876 (Month) (Day) (Year)

7-AGE, *46* yrs. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Labor* (b) General nature of industry, business, or establishment in which employed (or employer). *Work 040*

9-BIRTHPLACE, (State or Country), *Russia*

10-NAME OF FATHER, *Joseph Tobackman*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jack Lewis* (Address) *1439 E. Baltimore St.*

15-*OCT 5-1922*

Filed. 191. *ROBERT A. KRAUTER* Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

10-DATE OF DEATH, *Oct 5th*, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Laryngeal obstruction (Duration) *10-5* yrs. mos. ds.

CONTRIBUTORY (Secondary) *10-5* yrs. mos. ds.

(Signed) *J. H. Miller* M. D. (Coroner.)

10-5 1922 (Address) *1439 E. Baltimore St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. *10-5* yrs. mos. ds. In the State. *10-5* yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Northman Circle* DATE OF BURIAL, *10/8*, 1922

20-UNDERTAKER *Jack Lewis* ADDRESS *1439 E. Baltimore St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

A diagnosis made of Laryngeal growth from other history

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia" unqualified, is indefinite); *Tuberculosis of the lungs, meninges,*

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho-pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia," (merely symptomatic), "At-rophy," "Collapse," "Coma," "Convulsions," "De-bility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite dis-ease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septichæmia," "PUERP-ERAL peritonitis," etc. State cause for which sur-gical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Ex-amples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homi-cide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under head of "Contributory."

Certificates will be returned for additional in-formation which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hæmorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyæmia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicæmia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

68095 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 68095

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 N Stricker

ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Ambros

(a) RESIDENCE. No. 14 N Stricker

ST. WARD.

(If nonresident give city or town and State)

(Usual place of abode) 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Andrus Ambros (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7 AGE 31 Years - Months - Days If LESS than 1 day, hrs. or min. Nuknow -1882

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York N.Y.

10 NAME OF FATHER Andrus Kaszlavckas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Maculaitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Andrus Ambros (Address) 14 N Stricker Street

15 Filed 19-1922 ROBERT A. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 October 19 22

17 I HEREBY CERTIFY, That I attended deceased from 3 September 19 22, to 30 September 19 22, that I last saw h. alive on 30 September 19 22, and that death occurred, on the date stated above, at 5 p m. The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. 6 mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Paca, M. D.

. 19 (Address) 605 S. Paca St., Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer

Oct. 7th 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas

425 S Paca St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in years, months, and days. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

268096		La Porte		HEALTH DEPARTMENT—CITY OF BALTIMORE	
1-PLACE OF DEATH		CERTIFICATE OF DEATH.		188-103 D 68096	
City of BALTIMORE: (No. <i>John Hopkins</i> St. <i>3</i> Ward)		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)			
2-FULL NAME <i>James Elder Lepore</i>		(Residence in Baltimore: No. <i>1630 E Pratt</i> St.; yrs., mos., ds.)			
PERSONAL AND STATISTICAL PARTICULARS.				CORONER'S CERTIFICATE OF DEATH.	
3-SEX <i>Male</i>	4-COLOR OR RACE <i>White</i>	5-Single, Married, Widowed, or Divorced. (Write the word.) <i>Married</i>	16-DATE OF DEATH, <i>Oct 4</i> , 192 <i>2</i> (Month) (Day) (Year)		
6-DATE OF BIRTH, <i>Nov 11</i> , 191 <i>2</i> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>Autopsy</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>Autopsy</i> find that said deceased came to <i>his</i> death (Inquest, autopsy or inquiry.) on the day stated above.		
7-AGE, <i>8</i> yrs. <i>11</i> mos. <i>22</i> ds. If LESS than 1 day, hrs. or min.?			The CAUSE OF DEATH* was as follows: <i>Concussion of brain</i> <i>Autopsy made at Hospital</i> <i>Killed by automobile on Oct 2/22</i> (Duration) yrs. mos. ds.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work <i>High School</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Student</i>			CONTRIBUTORY Investigation <i>by</i> <i>Rich Frazier</i> 7:30 PM. (Signed) <i>J. S. Tolson</i> M. D. (Coroner.) 192 <i>2</i> (Address) <i>508 E Pratt</i>		
9-BIRTHPLACE, (State or Country), <i>Baltimore</i>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
PARENTS.	10-NAME OF FATHER, <i>Alfred Lepore</i>		18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.		
	11-BIRTHPLACE OF FATHER, <i>Italy</i>		Where was disease contracted, if not at place of death?		
	12-MAIDEN NAME OF MOTHER, <i>Anna Elder</i>		Former or usual residence		
	13-BIRTHPLACE OF MOTHER, <i>Italy</i>		19-PLACE OF BURIAL OR REMOVAL, <i>Emmitsburg Md</i> DATE OF BURIAL, <i>Oct 6</i> , 192 <i>2</i>		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Alfred Lepore</i> (Address) <i>1630 E Pratt</i>			20-UNDERTAKER, <i>Wendel Pippelston</i> ADDRESS <i>37 S. Ann St</i>		
15- Filed <i>OCT 5 - 1922</i> Registrar.					

PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. -1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Monmouth Ct ST. 7 WARD)

2-FULL NAME

(a) RESIDENCE NO. 2002 Monmouth Ct

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? 30 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Znowina

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE Years 63 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Kasper Warczowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Jadwiga

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jacob Znowina (Address) # 2002 Monmouth Ct.

15 Filed Robert P. Harrison, 19 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept. 19, 19 22, to Oct. 4, 19 22, that I last saw him alive on Oct. 3, 19 22

and that death occurred, on the date stated above, at 3:40 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

CONTRIBUTORY (Secondary) Coronary Failure (duration) yrs. mos. ds.

18 Where was disease contracted At home if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs (Signed) Chas. J. Keer, M. D.

(Address) 408 S. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Stanislaus Cem. DATE OF BURIAL Oct. 7 19 22

20 UNDERTAKER M. J. Sadowicki ADDRESS 405 S. Amst.

D 68098

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68098

CERTIFICATE OF DEATH.

111-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

University Hospital

ST. No

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Michael Wolf

(a) RESIDENCE. NO.

810 S. 7th St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed or divorced

HUSBAND of

(or) WIFE of

Josephine Wolf

6 DATE OF BIRTH (month, day, and year)

Not obtained

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Batto. Copper Works.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Nicholas Wolf

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Anna (?)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

(Address)

Josephine Wolf.
810 S. 7th St.

15

Filed

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

October 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 29 1922, to October 4 1922

that I last saw him alive on October 4 1922

and that death occurred, on the date stated above, at 3.07 P. m.

The CAUSE OF DEATH* was as follows:

Perforated gastric ulcer

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

Diffuse peritonitis - Brachypneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

if not at place of death?

unknown

Did an operation precede death?

Yes

Date of

9/29/22

Was there an autopsy?

Yes

What test confirmed diagnosis?

Operation & Autopsy

(Signed)

Anthony V. Buchanan, M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oak Lawn Cem.

Oct 7 1922

20 UNDERTAKER

Lilly and Zieles

ADDRESS

403 S. Wolfe

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

OCT 5-1922

Burial Permit Clerk.

D 68099

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68099

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 903 S. First St. ST., 26 WARD)2. FULL NAME Thomas B. Barrett.(a) RESIDENCE NO. 903 S. First St. ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of none6 DATE OF BIRTH (month, day, and year) July 13-19217 AGE Years 1 Months 2 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) infant school
(c) Name of employer none9 BIRTHPLACE (city or town) (State or country) Balto. Md.10 NAME OF FATHER John Barrett.11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.12 MAIDEN NAME OF MOTHER Elizabeth Mackessy13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.14 Informant Elizabeth Barrett.
(Address) 903 S. First St.15 Robert F. Harralson,

Filed

19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 3rd 192217 I HEREBY CERTIFY, That I attended deceased from Sept 26, 1922, to Oct 3, 1922, that I last saw him alive on Oct 2, 1922,and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

exhaustion following
Eastern enteritis(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Mal nutrition, indigestion (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Wright, M. D.10/3, 1922 (Address) 1514 S. Vermont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

20 UNDERTAKER

Lilly and Zeiler

DATE OF BURIAL

Oct 5th 1922

ADDRESS

403 S. Wolfe St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(Residence in Baltimore: No.

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

..... (Month) (Day) (Year)

7-AGE.

68 yrs.....moa.....da.

It LESS than 1 day.
.....hrs. or.....min.?

8-OCCUPATION:

-OCCUPATION:
 (a) Trade, profession, or particular kind of work.....
 (b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country).

10-NAME OF
FATHER,

**11-BIRTHPLACE
OF FATHER
(State or Country),**

12-MAIDEN NAME
OF MOTHER

**13-BIRTHPLACE
OF MOTHER**
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) . .

(Address)

18-

Robert T. Hartman

....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

16-DATE OF DEATH....., 1927
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Sep. 24 1922, to Oct 3 1922,
that I saw h. alive on Oct 3 1922,
and that death occurred, on the date stated above, at 9 p.m.
The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)..... M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?.....

Former or
usual residence

10-PLACE OF BURIAL OR REMOVAL.

20-UNDERTAKER

DATE OF BURIAL.

DATE OF BIRTH: Oct. 6th, 1922

ADDRESS

20-UNDERTAKER
ADDRESS
Peter Nicholas 2080 Eastern Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-001 D 68101

1. PLACE OF DEATH

CITY OF BALTIMORE: JOHNS HOPKINS HOSPITAL ST.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Cleo Layton

(a) RESIDENCE NO.

408 McIver

ST.

WARD

Sanford, N.C.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 10-1905

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

17225

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N. Carolina

10 NAME OF FATHER

Chas. R. Layton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Etta Underwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

14

Informant JOHNS HOPKINS HOSPITAL (Address)

15

Robert P. Harrison

5-1922

Filed

19

Burial Permit 4122

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 27 1922, to Oct 5 1922.that I last saw her alive on Oct 5 1922,and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus, congenital malformation of ventricles, focal epilepsy(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at homeDid an operation precede death? Yes Date of Sept 29 22Was there an autopsy? Partial (head)What test confirmed diagnosis? X-ray of skull(Signed) E. R. Reicher M.D.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Sanford N.C.

20 UNDERTAKER

Joseph Ahrens

DATE OF BURIAL

Oct 5 1922

ADDRESS

221 B Way

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Dr. WM. A. B. SELLMAN

HEALTH DEPARTMENT—CITY OF BALTIMORE

1068102

D 68102

CERTIFICATE OF DEATH.

164

D 68102

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 York Court

ST. 17

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Carol Ann Underwood

(Residence in Baltimore: No. 26 York Court

St. 17 yrs. 11 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE, ^{single}
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept. 10

(Month)

(Day)

1840
(Year)

7-AGE,

8.2 yrs. 0 mos. 24 ds.

If LESS than 1 day,

....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

Maryland

PARENTS.

10-NAME OF FATHER,

Edwin C. Underwood

11-BIRTHPLACE OF FATHER
(State or Country),

Baltimore City

12-MAIDEN NAME OF MOTHER

Chapman

13-BIRTHPLACE OF MOTHER
(State or Country),

Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles C. Caldwell

(Address)

26 York Court

15-

Filed

191

ROBERT W. KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

October

4, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

April 191, to Oct 4 1922,

that I saw her alive on Oct 4 1922,

and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

General debility

per vaginam

(Duration) 1 yrs. 10 mos. 10 ds.

CONTRIBUTORY
(Secondary)

(Duration) 1 yrs. 10 mos. 10 ds.

(Signed) W. H. B. Selman M. D.

Oct 5, 1922 (Address) 5 E. 13th St. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

Oct 6, 1922

20-UNDERTAKER

ADDRESS

George J. Smith

1000 E. 13th St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *South Baltimore Hospital*

REGISTERED NO. C

CITY OF BALTIMORE: (No. *2520* ST.; *15* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Alex. Campbell Black*(Residence in Baltimore: No. *2118 St. North Ave* St.; *74* yrs., *10* mos., *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Widowed* (Write the word.)6-DATE OF BIRTH. *December 3, 1847* (Month) (Day) (Year)7-AGE. *74 yrs., 10 mos., 2 ds.* If LESS than 1 day,hrs. ormin.?8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Insurance* (b) General nature of industry, business, or establishment in which employed (or employer). *Nat'l Relief Socy*9-BIRTHPLACE, (State or Country). *Balto. Md*10-NAME OF FATHER. *John Black*11-BIRTHPLACE OF FATHER (State or Country). *Balto. Md*12-MAIDEN NAME OF MOTHER *Rebecca Troxell*13-BIRTHPLACE OF MOTHER (State or Country). *Balto. Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Earl H. Black*(Address) *2327-W-North Ave*15- *OCT 6-1922* Filed., 191... ROBERT R. KRAUTER, Registrar.Burial Permit *68103*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *5th, 1922* (Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from *Sept. 5th, 1922, to Oct. 5th, 1922*that I saw him alive on *Oct. 4th, 1922*and that death occurred, on the date stated above, at *8:00 a.m.*The CAUSE OF DEATH* was as follows: *Cerebral hemorrhage on 8-5-22 with right left hemiplegia. Patient rallied & did well for 3 weeks. Then began to sink as though there was additional hemorrhage CONTRIBUTORY. Secondary. never original site.*

(Duration) yrs. mos. ds.

(Signed) *A. H. Hoffman* M. D.10-5-1922 Address *3402 Walbrook Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. *0* yrs. *1* mos. *0* ds. In the *74* yrs. *10* mos. *2* ds.Where was disease contracted, if not at place of death? *2118 W. North Ave*Former or usual residence *2118 W. North Ave*19-PLACE OF BURIAL OR REMOVAL, *Green Mt. Cemetery* DATE OF BURIAL, *Oct 7, 1922*20-UNDERTAKER *MOWEN COMPANY* ADDRESS *108 W. NORTH AVE.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68104

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1138 E. North Ave.

ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Lee McShane

(a) RESIDENCE. No. 1138 E. North Ave.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Caroline B. McShane

6 DATE OF BIRTH (month, day, and year) Aug. 20, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
60		1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

10 NAME OF FATHER Lawrence McShane

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann O'Hare

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland14 Informant Caroline B. McShane
(Address) 1138 E. North Ave.15 OCT 6-1922 ROBERT W. KAUFER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 3rd 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 4th, 1922, to Oct. 3rd, 1922, that I last saw him alive on Oct. 3rd, 1922, and that death occurred, on the date stated above, at 10:20 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds. 6

CONTRIBUTORY Chronic Interstitial Nephritis

(Secondary) (duration) 3 yrs. mos. ds.

18 Where was disease contracted Unknown
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs and symptoms

(Signed) Daniel Miller, M. D.

, 19 (Address) 1506 N Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery

Oct. 7, 1922

20 UNDERTAKER

ADDRESS

Wm. C. Black,

927 N. Broadway

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68105 HEALTH DEPARTMENT—CITY OF BALTIMORE 68105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 1116 Brewer St., 17⁹⁰ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Payson

(Residence in Baltimore: No. 1116 Brewer St., 52 yrs., 16 mos., 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, colored 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Sept. 18, 1870 (Month) (Day) (Year)

7-AGE, 52 yrs., 16 mos., 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, maid
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Peter Blakey

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Lydia Wilson

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Annie Kay
(Address) 544 Dolphin St.

15- Filed OCT 6-1922 ROBERT R. KAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 4, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
organic heart disease

(Duration) 3 yrs., 3 mos., 16 ds.

CONTRIBUTORY (Secondary) no injury

(Signed) J. T. Hennessy, M. D. (Coroner.)
Oct 4, 1922 (Address) 2802 E. Monument St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery DATE OF BURIAL, Oct 6, 1922

20-UNDERTAKER, Samuel McQuisley ADDRESS 578 W. Biddle St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68106

CERTIFICATE OF DEATH.

D 68106

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 198th ST.; 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 708 198th St.; 8 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE

Colored

5-STATUS

Widow
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Unknown
(Month) (Day) (Year)

7-AGE

78 yrs., 0 mos., 0 ds.If LESS than 1 day,
...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Domestic
Helper

9-BIRTHPLACE,

(State or Country), MD

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emmett W. Wiley(Address) 348 Bedford St.

15-

Filed 101 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Feb. 5th, 1942
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Sept. 1921 to Feb 5th 1942that I saw her alive on Oct. 4th 1941, and that death occurred, on the date stated above, at 1344 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
(Duration) 5 yrs., 1 mos., 1 ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis
(Signed) R. J. Wiley M. D.
1942, 101 (Address) 927 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the 0 yrs., 0 mos., 0 ds. State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Coopersville, Tollet Co.Oct 6, 1942

20-UNDERTAKER

ADDRESS

Emmett W. Wiley348 Bedford St.Burial Permit No. 101

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68107

CERTIFICATE OF DEATH.

D. 68107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 Little George

ST.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 718 Little George

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of Elizabeth Hutchins (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7 1867

7 AGE 55 Years 5 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Thomas Hutchins

11 BIRTHPLACE OF FATHER (city or town) Cambridge (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Chesterton (State or country) Md

14 Informant (Address) 708 Little George St

15 OCT 5 - 1922 ROBERT R. KAUFER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1922, to Oct 4, 1922, that I last saw him alive on Oct 4, 1922, and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John R. Kelly M. D.

19 (Address) 753 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 68108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3216 O'Donnell* ST. *70* WARD) *44*

2-FULL NAME

(a) RESIDENCE. NO. *3216 O'Donnell* ST. *1* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1868 Mar 3*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*54**6**22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Jacob Kot

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Becia Marta

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

John Kocyan 3216 O'Donnell St

15

Filed *1916-1744*

ROBERT B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 3* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

Nov 30 19*21*, to *Oct 3* 19*22*that I last saw her alive on *Oct 2* 19*22*and that death occurred, on the date stated above, at *130 A.M.*

The CAUSE OF DEATH* was as follows:

Cancer of Liver metastases of viscera(duration) yrs. *11* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *11 mos*Was there an autopsy? *no*What test confirmed diagnosis? *Exploratory*(Signed) *mrs m. Avoog* M. D.1916-1744 (Address) *839 O. Ellwood av*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St Stanislaus Cem Oct 7 19*22*

20 UNDERTAKER

ADDRESS

Stephen J. Falkowski

Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

158717

D 68109

CERTIFICATE OF DEATH.

16-003

D 68109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL, 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Paul Murphy

(a) RESIDENCE NO.

240 S. Chapel St. City

WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced

Deceased Leater & Nellie Murphy Parents6 DATE OF BIRTH (month, day, and year) March 25, 19227 AGE Years 4 Months 6 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

CH

(c) Name of employer

CH

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Maryland

10 NAME OF FATHER

Leater Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto, Md.

12 MAIDEN NAME OF MOTHER

Nellie Hagan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto, Md.

14

Informant JOHNS HOPKINS HOSPITAL (Address) Accorale

15

Filed 1922ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 28, 1922 to Oct 5, 1922.that I last saw him alive on Oct 5, 1922, at 3:30 A.M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
Dysentery (Flexner)CONTRIBUTORY (Secondary) Acute pyelitis (duration) yrs. mos. 21 ds.(duration) yrs. mos. 7 ds. ?18 Where was disease contracted if not at place of death? At homeDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Stool Cultures
(Signed) A. H. Meek, M. D.19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cem.

DATE OF BURIAL

Oct 7, 1922

20 UNDERTAKER

J. A. Moran 3000 E. Balto, St.

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68110

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68110

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: No. *Engleide & Hamlin* St. *77* Ward)

Registered No. C.....

2-FULL NAME.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *Engleide & Hamlin* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH.

March 21 19*22*
(Month) (Day) (Year)

7-AGE,

6 yrs. *15* mos. *15* ds.

If LESS than 1 day,

.... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... *nurse*

9-BIRTHPLACE,

(State or Country), *Balto Md.*

10-NAME OF FATHER

Geo. P. Engler

11-BIRTHPLACE OF FATHER,

(State or Country), *Ohio*

12-MAIDEN NAME OF MOTHER

Florence Lagler

13-BIRTHPLACE OF MOTHER,

(State or Country), *N. Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *George P. Engler*

(Address) *Engleide and Hamlin Ave.*

15-

FILED

OCT 8 - 1922

ROBERT B. KRAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 5 19*22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. mos. ds.

(Signed)..... M. D.

(Coroner.)

192..... (Address).....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Druid Ridge

DATE OF BURIAL,

Oct 7 19*22*

20-UNDERTAKER,

John A. Moran

ADDRESS

3000 E. Balto St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68111

CERTIFICATE OF DEATH.

90 D 68111

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *812 Burgundy* ST. *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah Snooks(a) RESIDENCE. NO. *812 Burgundy*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female *White* *Widow*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Samuel Snooks*

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*78*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Genova*

10 NAME OF FATHER

Moses Snooks

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Genova

12 MAIDEN NAME OF MOTHER

Esther Snooks

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Genova

14

Informant
(Address)*Becky Snooks*
808 Burgundy St

15

Filed

19

*OCT 6 - 1922**ROBERT A. KRAMER*

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 6* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 19*22*, to *Oct. 6*, 19*22*,that I last saw *her* alive on *Oct. 4*, 19*22*,and that death occurred, on the date stated above, at *1.30 a.m.*

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation(duration) yrs. *6* mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harry Boyd*, M. D.1922 (Address) *602 Franklin St. Bldg.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebrew Fresh**Oct 6* 19*22*

20 UNDERTAKER

ADDRESS

*J. Ahrens & Co**1611 Madison*

D 68112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68112

1-PLACE OF DEATH

CITY OF BALTIMORE, MD.

ST.: V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1922, to Oct 5, 1922,

that I last saw him alive on Oct 5, 1922,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarct.

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 6 - 1922

ROBERT A. KRAUTER
Burial Permit Clerk

Joseph Ahrens

221 Burg-

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68113

CERTIFICATE OF DEATH.

D 68113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Wildes + Lake W. Goodas* ST., *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Anna B Kemper*(a) RESIDENCE NO. *Wildes + Lake Ave* ST., *27* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

6a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Henry Kemper*6 DATE OF BIRTH (month, day, and year) *Feb 1858*7 AGE Years *84* Months *8* Days *8* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Barania*
(State or country)10 NAME OF FATHER *Dout Knorr*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Barania*12 MAIDEN NAME OF MOTHER *Dout Knorr*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Barania*14 Informant *Maudeline Ammerhause*(Address) *Wildes + Lake Ave + Goodas*

15

Filed

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 4* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Dec. 3*, 19*18*, to *Oct. 4*, 19*22*,that I last saw her alive on *Oct. 4*, 19*22*,and that death occurred, on the date stated above, at *4* P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis(duration) *4* yrs. mos. ds.CONTRIBUTORY *Cerebral Hemorrhage*
(Secondary)(duration) yrs. mos. *1* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Clinical*(Signed) *W. C. Bess*, M. D.10-4, 1922 (Address) *5600 York Rd Balto Md*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

*Balto Cem.**Oct 7* 19*22*

20 UNDERTAKER

ADDRESS

Wm. Cook 602 E. Yacht

Physician should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68114

CERTIFICATE OF DEATH

60-001

1-PLACE OF DEATH

Church Home and Dr.

REGISTERED

D 68114

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 15 WARD

2-FULL NAME

Mary E. Gaston

(a) RESIDENCE NO.

Nallbrook ave + Longwood st.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 5, 1857

7 AGE

Years

Months

Days

65

1

0

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ret School teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. md

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

"

12 MAIDEN NAME OF MOTHER

"

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

"

14

Informant (Address)

Walter F. Macneal 1631 N. Broadway

15

Filed

10-22

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 29, 1922, to Oct 5, 1922,

that I last saw her alive on Oct 5, 1922,

and that death occurred, on the date stated above, at 2:00 p. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept 30, 1922

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Cayetano Panethier, M. D.

, 19 (Address) Church Home and Dr.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount Cem.

10/7/1922

20 UNDERTAKER

ADDRESS

Wm. Beck, 502 E. North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

68115

CERTIFICATE OF DEATH.

D 68115

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

810 E. 70th

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James N. P. Bailey

(a) RESIDENCE. NO.

810 E. 70th

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Lizzie V. Bailey

6 DATE OF BIRTH (month, day, and year)

Oct 4, 1853

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69

0

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ret. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore md. W.D.C.

10 NAME OF FATHER

John W. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md.

12 MAIDEN NAME OF MOTHER

Ella Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md.

14

Informant (Address)

Lizzie V. Bailey

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 5, 1922

17

I HEREBY CERTIFY, That I attended deceased from

October 1st, 1918, to October 5th, 1922

that I last saw him alive on October 5th, 1922

and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary)

Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

at place of death

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical examination and analysis of tissues

(Signed)

, 19 (Address)

J. W. 9. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmt. Cemetery 10/9/1922

20 UNDERTAKER

ADDRESS

Mr. Cook, 502 E. North Ave.

D 68116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68116

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *2037 Penna Ave* St. *14* Ward) *90*

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2037 Penna Ave* St.; yrs. *84* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.) *widower*

6-DATE OF BIRTH,

about 1838
(Month) (Day) (Year)

7-AGE,

84 yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).*retired Carpenter*

9-BIRTHPLACE, (State or Country),

Ba. Co. Md.

10-NAME OF FATHER,

Geo. Bowley

11-BIRTHPLACE OF FATHER, (State or Country),

Md.

12-MAIDEN NAME OF MOTHER,

Murphy

13-BIRTHPLACE OF MOTHER, (State or Country),

Murphy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Daniel Easton

(Address)

*Penna Ave*15-*OCT 6 - 1922*

Filed

192

HAM

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 5, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to *this* death on the day stated above.

The CAUSE OF DEATH* was as follows:

myocardial degeneration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. S. Newman* M. D. (Coroner.)*Oct. 6, 1922* (Address) *2802 E. Lombard*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*London Park**Oct 6, 1922*

20-UNDERTAKER

ADDRESS

*Daniel Easton**Penna Ave*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *810 Tawman* ST. *17* WARD)

2-FULL NAME

(Residence in Baltimore: No. *810 Tawman* St.;yrs., *3* mos.,ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

1891

(Month)

(Day)

(Year)

7-AGE,

31

yrs.,mos.,ds.

If LESS than 1 day,

.....hrs. ormin.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic
South Lamb

9-BIRTHPLACE,

(State or Country).

South Carolina

10-NAME OF FATHER,

Auburn

11-BIRTHPLACE OF FATHER

(State or Country).

South Carolina

12-MAIDEN NAME OF MOTHER

Auburn

13-BIRTHPLACE OF MOTHER

(State or Country).

South Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Matth. French*(Address) *810 Tawman St.*

OCT 6 - 1922

Filed

191

Registrar.

16-DATE OF DEATH.

October 4th 1922
August 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

August 1922 to *Oct 4th 1922*that I saw him alive on *Oct 3rd 1922*and that death occurred, on the date stated above, at *2 PM* m.

The CAUSE OF DEATH* was as follows:

Full Tuberculosis

(Duration)yrs.,mos.,ds.

CONTRIBUTORY (Secondary)

(Duration)yrs.,mos.,ds.

(Signed) *H. L. French* M. D.1922, 191 (Address) *810 Tawman St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of deathyrs.,mos.,ds. In the Stateyrs.,mos.,ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

West Auburn

DATE OF BURIAL,

Oct 6, 1922

20-UNDERTAKER

Samuel Easton

ADDRESS

916 Penna St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68118

D 68118

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 238 Carey St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 238 N. Carey St. St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Single

6-DATE OF BIRTH.

April 10, 1861
(Month) (Day) (Year)

7-AGE.

61 yrs. 4 mos. 24 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House

work

9-BIRTHPLACE, (State or Country),

Va.

10-NAME OF FATHER,

David Campbell

11-BIRTHPLACE OF FATHER (State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Sarah E. Poole

13-BIRTHPLACE OF MOTHER (State or Country),

England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Miss Julia M. Campbell

(Address)

238 N. Carey St.

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 4, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 29, 1922, to Oct 4, 1922, that I saw him alive on Oct 3, 1922, and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. 3 mos. ds.
Initial Insufficiency(Signed) J. M. H. Morgan, M. D.
Oct 4, 1922 (Address) 101 N. Carey St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Alexandria Va.

DATE OF BURIAL,

Oct 7, 1922

20-UNDERTAKER

W. H. Rounton

ADDRESS

2238 N. Smith St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

68119 HEALTH DEPARTMENT—CITY OF BALTIMORE 68119

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 W. Milton Ave. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 4 W. Milton Ave. ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? 60 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Margaret B. Doetzer

6 DATE OF BIRTH (month, day, and year)

March 29/1843

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

7765

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Frank Doetzer

11 BIRTHPLACE OF FATHER (city or town)

Germany

(State or country)

12 MAIDEN NAME OF MOTHER

Margt. Burkhardt

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant

(Address)

Margaret B. Doetzer4 W. Milton Ave.

15

Filed

1922ROBERT H. KRAUTERBarclay Parrott

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 28, 1922, to Oct 4, 1922.that I last saw him alive on 1, 3, 1922.and that death occurred, on the date stated above, at 7 11 a.m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Arthur H. ... M. D.10/16/1922 Address 2600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Church 1922

20 UNDERTAKER

ADDRESS

Lilly & Ziller 4001 No. 5

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68120

CERTIFICATE OF DEATH.

D 68120

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. *651 Josephine* ST. *4* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *7* yrs. *0* mos. *0* ds.How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male Col.

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 19 '1884*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*37**9**11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Shoe Store

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

OCT 6 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Sept 30 1922*

17 I HEREBY CERTIFY, That I attended deceased from

Aug 3, 1922 to *Sept 30, 1922*that I last saw him alive on *Sept 30, 1922*and that death occurred, on the date stated above, at *6:30 a.m.*

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

CONTRIBUTORY (Secondary)

(duration) yrs. *2* mos. *0* ds.(duration) yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *10/1/22*Was there an autopsy? *No*What test confirmed diagnosis? *Symptoms*(Signed) *J. H. Broome, M.D.*, 19 (Address) *1100 N. Broadway*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *1303*

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCASION CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68121

D 68121

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Carroll ST.; 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 1111 Carroll ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. Life

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Harry H. Grigg

6 DATE OF BIRTH (month, day, and year) May 1st 1892

7 AGE

30

Years

Months

Days

If LESS than

1 day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

OCT 6 - 1922

ROBERT A. GANTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1 - 1922 to Oct 5, 1922

that I last saw him alive on Oct 5, 1922

and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Erysipelas

Simple (duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted
if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Samuel M. Bann M. D.

16122 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Lay Cem Oct 9, 1922

20 UNDERTAKER

Joseph B Cook 1003 N. Baltimore

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68122

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. *Foot of Euter St.* St. *3* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Unknown* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Unknown*

6-DATE OF BIRTH, *Unknown* (Month) (Day) (Year)

7-AGE, *About 25* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Unknown* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Unknown*

10-NAME OF FATHER, *Unknown*

11-BIRTHPLACE OF FATHER, (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER, (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

OCT 6 - 1922

ROBERT A. KRAUTER

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Sept 26* (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquest* find that said deceased came to his death *topsy or inquiry* on the day stated above.

The CAUSE OF DEATH* was as follows:

Presumably Accidental Drowning (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *Thos. B. Barton* (Address) *Curtis Bay*

*State the Disease Causing Death, or, in deaths from violent Causes, state (1) Means of Injury; and (2) whether accidental, Suicidal, or Homicidal. *Bald*

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

PUBLIC CEMETERY.

20-UNDERTAKER,

ADDRESS

WILLIAM J. HIGGINS

Per. WM. E. WOODALL

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68123

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68123

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2309 E Preston St. 857 Ward)

2-FULL NAME John George Wochner

(Residence in Baltimore: No. 2309 E Preston St.; yrs. 75 mos. ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.		CORONER'S CERTIFICATE OF DEATH.	
3-SEX Male	4-COLOR OR RACE White	5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed	16-DATE OF DEATH, Oct 6 1922 (Month) (Day) (Year)
6-DATE OF BIRTH, June 28 1880 (Month) (Day) (Year)		17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.	
7-AGE, 72 yrs 3 mos 8 ds. If LESS than 1 day, hrs. or min.?		The CAUSE OF DEATH* was as follows: Probably Heart Disease (Natural Cause and nothing while driving 75 m.p.h.) (Duration) yrs. mos. ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work Retired (b) General nature of industry, business, or establishment in which employed (or employer) Cook 46		CONTRIBUTORY (Secondary) Had Diabetes for years (Duration) yrs. mos. ds. (Signed) J. S. Walter M. D. (Coroner.) Oct 6 1922 (Address) 508 E. Preston St.	
9-BIRTHPLACE, (State or Country) Baltimore Md		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS.	10-NAME OF FATHER, Gustav Wochner	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.	
	11-BIRTHPLACE OF FATHER, (State or Country), Germany	Where was disease contracted, if not at place of death?	
	12-MAIDEN NAME OF MOTHER, Catherine HaWaller	Former or usual residence	
	13-BIRTHPLACE OF MOTHER, (State or Country), Germany	19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Margaret Carmell Oct 9 1922	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Catherine Dyer (sister) (Address) 2309 E Preston St		20-UNDERTAKER, Louis Heeman 32 Broadway	
15- Robert P. Harrison, Registrar. Filed 1922			

D 68124

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68124

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry F. McFarlan(a) RESIDENCE NO. Unknown(Usual place of abode) about 30Length of residence in city or town where death occurred 30 yrs. mos. ds.ST. 76 WARD(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18577 AGE Years 65 Months -- Days -- If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records(Address) Municipal Hospital15 Robert P. McFarlan 19 1922Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 19 2217 I HEREBY CERTIFY, That I attended deceased from Dec. 5 19 21, to October 5 19 22, that I last saw him alive on October 5 19 22, and that death occurred, on the date stated above, at 1:45 P.M.
The CAUSE OF DEATH* was as follows:Carcinoma of prostate(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde M. Neil M. D.10/6/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Trinity Cemetery

20 UNDERTAKER

ADDRESS

E. Smith, Conklin 248 Eager

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68125

HEALTH DEPARTMENT—CITY OF BALTIMORE 68125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

4603 Pimlico Road 15

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Frank A Mc Donald

(Residence in Baltimore: No.

4623 Pimlico Rd

St.;

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

Married

6-DATE OF BIRTH.

Oct

3

1

(Month)

(Day)

(Year)

7-AGE,

49

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

Canada

10-NAME OF FATHER,

Michael B McDonald

11-BIRTHPLACE OF FATHER
(State or Country),

Canada

12-MAIDEN NAME OF MOTHER,

Jesse McKinnan

13-BIRTHPLACE OF MOTHER
(State or Country),

Canada

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ruthena McDonald

(Address)

4623 Pimlico Rd.

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct

4

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

OCT 4

1922, to

OCT 4

1922

that I saw him alive on OCT 4 1922,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration)

unknown

CONTRIBUTORY
(Secondary)

Acute

Indigestion

(Duration)

few hrs

(Signed)

C. B. Curtis M. D.

OCT 5, 1922 (Address) 5716 Park Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death

yrs.

mos.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cathedral Ave

OCT 7, 1922

20-UNDERTAKER

ADDRESS

Margaret J. Flynn

1427 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

D 68126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Longwood ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Bryan Templeman(a) RESIDENCE. No. 2013 Longwood ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed,

or Divorced (write the word)

widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

James A. Templeman6 DATE OF BIRTH (month, day, and year) March 29 1860

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

6277

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Alexandria
(State or country) Virginia10 NAME OF FATHER Hanson Bryan

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia12 MAIDEN NAME OF MOTHER Eleanor Barber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant

(Address)

E. B. Templeman
Clarkston W. Va.

15

Informant

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6th 19 22

17

I HEREBY CERTIFY, That I attended deceased from

June 20th, 19 22, to Oct 6th, 19 22,that I last saw her alive on Oct 5th, 19 22,and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Gastric carcinoma(duration) yrs. 5 mos. 5 days.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?at place of deathDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? X-ray

(Signed)

John J. Pennington, M. D.

, 19

(Address)

1826 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park CemeteryOct 7 1922

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North Ave

Physician should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-1922

Burial Permit Clerk.

D 68127 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68127

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Amos Ave ST., 31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Moore(a) RESIDENCE No. 1804 Hope St

(Usual place of abode)

ST., 31 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofHattie Moore6 DATE OF BIRTH (month, day, and year) 5/29/1895

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.2745

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workMachinist(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto Md.

10 NAME OF FATHER

John Moore11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto Md.

12 MAIDEN NAME OF MOTHER

Mary E Brown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto Md.

14

Informant
(Address)Hattie Moore
1804 Hope St

15

Date

Robert F. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5-1922

17

I HEREBY CERTIFY, That attended deceased from

Aug 1, 1922 to Oct 5, 1922,
that I last saw him alive on Oct 4, 1922and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted I do not know.
if not at place of death?Did an operation precede death? No Date of Was there an autopsy? NoWhat test confirmed diagnosis? Hydrolytic Dissection(Signed) Robert F. Harrison, M. D., 19 (Address) Main & Haywood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALWood Ridge Cem

DATE OF BURIAL

10/7/22

20 UNDERTAKER

Geo J. Ruth 1735 Haywood Ave

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

T6-1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

68128

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, 1 hr.
or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15 Filed

Robert P. Harraben,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

10.5.1922, to 10.6.1922

that I last saw him alive on 10/6.1922

and that death occurred, on the date stated above, at 12.15 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery

CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Martin, M. D.

10/6/1922 (Address) 102 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

6-1922

Burial Permit 6122

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68129

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1414 Battery Ave. St. 24 Ward)

Registered No. C.

2-FULL NAME

Mary E. Moon.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1414 Battery Ave. St.; yrs. 60 mos. 2 ds. 14)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)
Female. White. Widow.

6-DATE OF BIRTH, July 19th. 1862, 1 (Month) (Day) (Year)

7-AGE, 60 yrs. 2 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore, Md.

10-NAME OF FATHER, Do not know.

11-BIRTHPLACE OF FATHER, (State or Country), Do not know.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), William Moon. (son)

(Address), 1414 Battery Ave.

15- Robert P. Harrison,

Filed 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 3rd. 1922, 192 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injuries. Accidentally binned under an automobile which backed over an embankment. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Oct. 6th 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? Nabel Ave. Catonsville 10/2/22.

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Cedar Hill Cem 10/7 1922

20-UNDERTAKER, ADDRESS, J. Frew M. Bulby 130 E. Fort

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68130

CERTIFICATE OF DEATH.

122-002 D 68130

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5813 Bellona Ave Gorsus ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE (Usual place of abode) No. 5813 Bellona Ave Gorsus WARD

Length of residence in city or town where death occurred 69 yrs. 7 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of M. Pauline Moss Schleifer

6 DATE OF BIRTH (month, day, and year) Mar 1st 1853

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 69 7 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glorist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gorsus Md.

10 NAME OF FATHER Isaac Moss

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) M. Pauline Moss Schleifer 5813 Bellona Ave Gorsus

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1919, to Oct. 4, 1922, that I last saw him alive on Oct. 4, 1922, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis

CONTRIBUTORY (Secondary) (duration) 4 yrs. mos. ds. Haematemesis over

(duration) yrs. mos. ds. 7

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Haines, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Presbyterian Burial Ground

Oct 7 1922

ADDRESS

701 Hallway St.

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

17-1922

BRIEF FORM NO. 10

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)2. FULL NAME Maggie Gowins(a) RESIDENCE NO. 112 Winters Ave ST., 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND
(or) WIFE ofSamuel Jones (Cousin)6 DATE OF BIRTH (month, day, and year) Mar. 27, 18817 AGE Years Months Days If LESS than 1 day, hrs. or min.
41 7 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(11)

(c) Name of employer

(4)

9 BIRTHPLACE (city or town) (State or country)

(4)Pa

10 NAME OF FATHER

James C. Chamberlain

11 BIRTHPLACE OF FATHER (city or town) (State or country)

(4)Pa

12 MAIDEN NAME OF MOTHER

Mary Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

(11)Pa

14

Informant JOHNS HOPKINS HOSPITAL
(Address) Sec 20

15

Robert P. HARTMAN, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 21, 1922 to Oct 5 1922.that I last saw her alive on Oct 5 1922.and that death occurred, on the date stated above, at 145 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary emboliDied sudden about 6-8minutes after onset of symptoms

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial infarction

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of Sept 22, 22Was there an autopsy? yesWhat test confirmed diagnosis? autopsy(Signed) Karl H. M. D.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Weston Star Lane Catonsville

20 UNDERTAKER

Edmond H. Payne

DATE OF BURIAL

Oct-8 1922

ADDRESS

Edmond H. Payne
Catonsville

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCASION CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68132

D 68132

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Sarah Jackson(a) RESIDENCE NO. UnknownST. 76 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6-8 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18457 AGE Years Months Days If LESS than 1 day, hrs or min. 76 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's Co., Md. (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records,(Address) Municipal Hospital.15 Robert P. Harrison,Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 4 192217 I HEREBY CERTIFY, That I attended deceased from January 21, 1922, to October 4, 1922. that I last saw her alive on October 3, 1922. and that death occurred, on the date stated above, at 12:45 A.M. The CAUSE OF DEATH* was as follows:Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial insufficiency (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical (Signed) Clyde M. Hill M. D.10/4/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Bonnie Grace Barney Gray

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 1725Mrs Robert A. Elliott Ashland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68133 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68133

68133
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

REGISTERED NO. C

CITY OF BALTIMORE: (No. *Curtis Bay* ST. *25* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Savannah Co* St. *15* yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Single*

6-DATE OF BIRTH.

Do not know

(Month)

(Day)

(Year)

7-AGE.

21

yrs. mos. da.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Farmer

9-BIRTHPLACE. (State or Country).

B. heria

10-NAME OF FATHER.

Joseph E. Kr

11-BIRTHPLACE OF FATHER (State or Country).

B. heria

12-MAIDEN NAME OF MOTHER

Maria Lebecka

13-BIRTHPLACE OF MOTHER (State or Country).

B. heria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Joseph E. Kr*(Address) *Savannah Co*

15-

Robert P. Hartlock,

191

Marital Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

*Oct**5**1922*

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from

*Sept 1, 1922, to Oct 5, 1922,*that I saw him alive on *Oct 3, 1922,*and that death occurred, on the date stated above, at *10¹⁵ A. m.*

The CAUSE OF DEATH was as follows:

*Acute dilatation of**Heart**about 1 hr*

(Duration) yrs. mos. da.

CONTRIBUTORY *Myocarditis - Chronic*(Secondary) *Intubation of trachea*(Signature) *Walter S. Willett* M. D.*Oct 5, 1922* (Address) *2220 Garrison*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Oak Hill

DATE OF BURIAL,

Oct 7, 1922

20-UNDERTAKER

Frank E. Crockett

ADDRESS

1116 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

17-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68134

CERTIFICATE OF DEATH.

100-001

D 68134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2403 Orleans St.* ST., *6* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary F. Horby.

(a) RESIDENCE NO.

2403 Orleans St.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White.

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 18-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*1**4**17*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*Baltimore Md.*10 NAME OF FATHER *Anton Horby*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Balto. Md.*12 MAIDEN NAME OF MOTHER *Jenny May.*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md.

14

Informant (Address)

*Anton Horby 2403 Orleans St.**Robert P. Harrison,*

19

Registrar

Burial Permit No. 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 5 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Oct. 1-1922 to Oct. 5-1922*that I last saw him live on *Oct. 5-1922*and that death occurred, on the date stated above, at *11:00 P. m.*

The CAUSE OF DEATH* was as follows:

Branchial Pneumonia(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *Benj. S. Hayden*, M. D.10/6, 1922 Address *216 N. Caroline St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Holy Redeemer Cem.

DATE OF BURIAL

Oct. 7 1922

20 UNDERTAKER

Lilly and Ziehl

ADDRESS

403 S. Wofford

CAUTION—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68135

CERTIFICATE OF DEATH.

44 D 68135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Noonan(a) RESIDENCE No. 2007 Polton St.

ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofUnknown

6 DATE OF BIRTH (month, day, and year)

1846

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.76---

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workNone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Ireland10 NAME OF FATHER T. Fitzgerald

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland12 MAIDEN NAME OF MOTHER E. Murphy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant Hospital Records,
(Address) Municipal Hospital.

15

Filed Robert F. [illegible], 19 1922
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 19 22

17

I HEREBY CERTIFY, That I attended deceased from
October 5, 19 22, to October 5, 19 22.
that I last saw her alive on October 5, 19 22.
and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia of Stomach(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)(duration) 1 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde Macell, M. D.9/6/22 Address Municipal Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

St. Peter's Cemetery Oct 9 1922

20 UNDERTAKER

ADDRESS

Harry H. Witzke 1531 W. Lombard

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Physicians and state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68136

CERTIFICATE OF DEATH.

44 D 68136

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2630 Guilford ST., 17 WARD)

2. FULL NAME

(a) RESIDENCE No. 136 N Eighth ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel V. Jones

6 DATE OF BIRTH (month, day, and year)

7 AGE 51 Years 8 Months 18 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Harry H. Mc Frederick (Address) 1321 Highland Ave

15 Robert F. HARRISON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1922

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1922 to Oct 5, 1922, that I last saw him alive on Oct 5, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. L. Long, M. D.

106 1922 (Address) 2701 Eastern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

Harry H. Witzke 1531 W Lombard

D 68137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68137

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4411 Springdale Ave 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Milton Kemp(a) RESIDENCE NO. 4411 Springdale Ave ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9, 19227 AGE 1 Years 1 Months 27 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md10 NAME OF FATHER Joseph M. Kemp11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) md12 MAIDEN NAME OF MOTHER Helen E. McClanahan13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) md14 Informant Joseph M. Kemp (Address) 4411 Springdale Ave

15 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 192217 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1922, to Oct 6, 1922, that I last saw him alive on Oct 6, 1922, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Colitis(duration) yrs. mos. 21 ds.CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted Balto. County if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Thuse of Acute Colitis(Signed) Walter C. Bacon, M. D.19/6, 1922 (Address) 100 E 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Sandon Park CemeteryOct. 9 1922

20 UNDERTAKER

ADDRESS

George J. Smith1000 W. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of-PA-TION is very important. See instructions on back of certificates.

17-1922

1922

Registrar

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68138

D 68138

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2008 Lehigh ST.: 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Aunie M. Steinmire

(a) RESIDENCE. NO.

2008 Lehigh

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

(or) WIFE of

Steinmire

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

71

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Jacob Hurvey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Louis

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Aunie M. Steinmire 2008 Lehigh St.

15

Filed

Robert F. HARRISON,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Sep 3, 1922, to Oct 6, 1922.

that I last saw him alive on Oct 5, 1922.

and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W. White, M. D.

16, 1922 Address 5800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery Oct 9 1922

20 UNDERTAKER

ADDRESS

George J. Smith 1010 N. Fayette St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

C77-1822

Special Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68139

CERTIFICATE OF DEATH.

D 68139

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Aged Women's Home 19

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

M. Elizabeth Baker

(a) RESIDENCE. No.

1400 W Lexington

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

83

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hoopford Co Md

10 NAME OF FATHER

Charles Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Hoopford Co Md

12 MAIDEN NAME OF MOTHER

Mary Leachman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Hoopford Co Md

14

Informant (Address)

Ellen J. Jones Matron

15

ST 7-1922

Robert P. Harrison

Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Jan 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1921, to Oct 5, 1921

that I last saw him alive on Oct 5, 1921

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Woodward, M. D.

Cont. 19 (Address)

937 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Olivet Cemetery

Oct 7 1922

20 UNDERTAKER

ADDRESS

George J. Smith

Fayette St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68140

CERTIFICATE OF DEATH.

31 ✓ D 68140

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1826 Etting

ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace Halders

(Residence in Baltimore: No. 1826 Etting

St.; yrs. 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Aug —, 1889
(Month) (Day) (Year)

7-AGE,

33 yrs. 2 mos. — ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE,

(State or Country),

Va.

10-NAME OF FATHER,

John Halders

11-BIRTHPLACE OF FATHER (State or Country),

Virginia

12-MAIDEN NAME OF MOTHER

Lena Vennia

13-BIRTHPLACE OF MOTHER (State or Country),

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rebecca Halders

(Address) 1826 Etting St

15-

Filed Robert M. HARTMAN,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 6, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 1922, to Oct 6th 1922, that I saw him alive on Oct. 5th 1922 and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Pne. Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 2 yrs. mos. ds.

(Signed) Dr. Lee Ellis, M. D.

10-6-1922, 1922 (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Lancaster Va.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Lancaster Va 10-8-1922

20-UNDERTAKER

ADDRESS

George T. G. Gibson 513 Avenue

Via Transasur whf

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

ST 7-1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68141 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68141

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hosp* ST. *9* WARD)

2-FULL NAME

(a) RESIDENCE No. *1435 E. Hoffman* ST. *9* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs. *—* mos. *—* ds. How long in U. S., if of foreign birth? *45* yrs. *—* mos. *—* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced, (write the word) *M.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs. Josephine Sommers*

6 DATE OF BIRTH (month, day, and year) *February 16 1866*

7 AGE Years *56* Months *7* Days *20* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *in Brewery*

9 BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER *Henry Sommers*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Wm. Knorr*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Wm. Knorr*

14 Informant *Mrs. Josephine Sommers* (Address) *1435 E. Hoffman St.*

15 Filed *OCT 17 - 1922* 19

Registrar *H. A. W.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 6 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Sept. 12*, 19*22*, to *Oct. 6*, 19*22*, that I last saw him alive on *Oct. 6*, 19*22*.

and that death occurred, on the date stated above, at *4:00 p. m.*

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue - gland neck - metastasis to lungs & liver.

(duration) yrs. *18* mos. *—* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *—* mos. *3* ds.

18 Where was disease contracted

if not at place of death? *Home*

Did an operation precede death? *No* Date of *1921*

Was there an autopsy? *No*

What test confirmed diagnosis? *Microscopic - histology*

(Signed) *W. C. Caldwell*, M. D.

(Address) *St. Agnes' Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Agnes' Heart Cemetery Oct. 9 1922

20 UNDERTAKER

Henry Boecklin 1301 E. Eager St.

D 68142

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68142

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 Willow ST., 10 WARD)

2. FULL NAME

Annie Sullivan

(a) RESIDENCE NO.

822 Willow

ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

(or) WIFE of

Late Peter Sullivan

6 DATE OF BIRTH (month, day, and year)

7 AGE

About 79

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not Known

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not Known

14

Informant (Address)

Mrs. Anna M. Lomb

734 Stanford Ave

OCT 7 - 1922

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922, to Oct 4, 1922.

that I last saw her alive on Oct 4, 1922.

and that death occurred, on the date stated above, at 12:15 A. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. C. Hornstein, M. D.

10/7, 1922 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Patrick's Cemetery

Oct 9, 1922

20 UNDERTAKER

Henry Hood & Son

ADDRESS

1301 E. Eager

D 68143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 68143

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *710 Singer St.* ST.: *13* WARD)2-FULL NAME *Arthur Payne Smith*(a) RESIDENCE. No. *710 Singer St.* ST.: _____ WARD. _____

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs. _____ mos. _____ ds. _____

How long in U. S., if of foreign birth?

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced *Married*

5a If married, widowed, or divorced

6 DATE OF BIRTH (month, day, and year) *May 2, 1888*7 AGE Years *34* Months *5* Days *3*

If LESS than 1 day, _____ hrs. _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF FATHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) *Martha Smith*15 Filed *Robert H. Harrison* Registrar

Burial Permit Clerk.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10-6-1922*17 I HEREBY CERTIFY, That I attended deceased from *Feb. 26*, 19*22*, to *Oct 6*, 19*22*, that I last saw him alive on *Oct. 5*, 19*22*, and that death occurred, on the date stated above, at *6:50* m. The CAUSE OF DEATH* was as follows:*Interference (Lobar) Pulmonary*CONTRIBUTORY (Secondary) *Myocarditis*

18 Where was disease contracted If not at place of death?

Did an operation precede death? *no* Date of _____Was there an autopsy? *no*What test confirmed diagnosis? *Polyspinal signs*(Signed) *R. F. Conner*, M. D.(Address) *3701 Roland Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *St Marys Hospital* DATE OF BURIAL *Oct 9 1922*20 UNDERTAKER *Wm Coyle* ADDRESS *5028 N. Ave*

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68144

CERTIFICATE OF DEATH.

D 68144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 E. Preston ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Miller(a) RESIDENCE. No. 1416 E. Preston ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE W5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 1, 22

7 AGE

Years

Months

Days

If LESS than 1 day, 6 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Ind.10 NAME OF FATHER Harry Edw. Miller11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Ind.12 MAIDEN NAME OF MOTHER Bertha Emma Preston13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Ind.

14

Informant Bertha Emma Miller (Address) 1416 E. Preston

15

Filed

Robert P. Miller

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1922, to Oct. 7, 1922, that I last saw her alive on Oct. 6, 1922, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Six month fetus (cause?)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of NoneWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) S. Lee Magness, M. D.(Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Beth CemeteryOct 7, 22

20 UNDERTAKER

ADDRESS

Paul Brockman1906 E. Preston

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Cause of Death is very important. See instructions on back of certificates.

7-1922

Burial Permit Office

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68145

CERTIFICATE OF DEATH.

118-002

D 68145

1-PLACE OF DEATH

Church Home for Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 146 N. Broadway

ST.,

WARD) 6

2-FULL NAME

Mr. Roy L. Phillips

(a) RESIDENCE NO.

Cambridge Md

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos. 11

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE OF

Edith Phillips

6 DATE OF BIRTH (month, day, and year)

Not - 11876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

about 46

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

Hardware

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Cambridge

10 NAME OF FATHER

George W. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Golden Hill

12 MAIDEN NAME OF MOTHER

Mary Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Robert P. Harrison, 15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 26 1922, to Oct 7 1922.

that I last saw him alive on Oct 7 1922

and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
General Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 3-1922

Was there an autopsy?

What test confirmed diagnosis? Clinical and Lab. Methods

(Signed) Richard E. Cottrell, M. D.

19 (Address) Church Home for Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cambridge Md. Oct 7 1922

20 UNDERTAKER

H. E. Hughes Truck Roadway

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

7-1922

Burial Permit Clerk.

68146 HEALTH DEPARTMENT—CITY OF BALTIMORE
D 68146

CERTIFICATE OF DEATH.

68146
90 D 68146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Milton Ave ST.; 7 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah H Everhart

(a) RESIDENCE. NO.

813 Milton Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

6 If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Charles H Everhart

6 DATE OF BIRTH (month, day, and year)

Nov 7-49

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

73

11

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H W

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Samuel R. Lilly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant
(Address)Edith R. Merck
813 W. Milton Ave

15

File

OCT 7-1922

ROBERT R. KRAUTER,

Registrar

Burial Place

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 7-1922

17

I HEREBY CERTIFY, That I attended deceased from

Sep 20, 19, to Oct 7, 1922

that I last saw her alive on Oct 6, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Walter W. White, M.D.

10/7/22 Address

2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Manchester Md. burial Oct 9 1922

20 UNDERTAKER

ADDRESS

Jacob Wink & Son Manchester Md

maison should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68147

CERTIFICATE OF DEATH.

113

D 68147

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 15-29 Barclay St.)

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 15-29 Barclay St. ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(h) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER John Gatewood11 BIRTHPLACE OF FATHER (city or town) va
(State or country)12 MAIDEN NAME OF MOTHER Bessie Holmes13 BIRTHPLACE OF MOTHER (city or town) va
(State or country)14 Informant John Gatewood
(Address) 15-29 Barclay St.15 OCT 8 - 1922 ROBERT N. MAUTER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 192217 I HEREBY CERTIFY, That (attended deceased from Oct 30 1922, to Oct 7 1922, that I last saw him on Oct 6 1922, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Eastern Colic and
General Heart weaknessCONTRIBUTORY (Secondary) General weakness
(duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? physical exam(Signed) Geo. H. Hall M. D.19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL
Laural Cemetery

DATE OF BURIAL

Oct 10, 1922

20 UNDERTAKER

Mrs Robert A. Elliott Ashlandmation should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS INMATE-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 68148

D 68148

129

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Mc Donough ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Charles Croxson

(a) RESIDENCE NO. 924 Mc Donough ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Croxson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 55 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hartford, Conn. (State or country)

10 NAME OF FATHER John Croxson

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Delia

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hattie Croxson (Address) 924 Mc Donough ST.

15 OCT 8 - 1922 ROBERT R. HAMILTON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-4-1922

17 I HEREBY CERTIFY that I attended deceased from Sept 23 - 1922 to Oct 4 - 1922 that I last saw him alive on Oct 3 - 1922

and that death occurred, on the date stated above, at 10:50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary)

(duration) Indefinite yrs. mos. ds.

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Gargier, M. D.

10-6-1922 (Address) 611 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE- MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Samuel Hensley M. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Division ST., 14 WARD)2-FULL NAME Louisa Wallace(a) RESIDENCE No. 2120 Division ST., 14 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Unknown7 AGE Years Months Days If LESS than
67 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown12 MAIDEN NAME OF MOTHER James Smith13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14

Informant Bennetta Mawhenge
(Address) 2120 Division St

15

Filed OCT 8 - 1922 ROBERT R. RAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-5-1922

17 I HEREBY CERTIFY, That I attended deceased from

July 2 - 1922 to Oct 5 - 1922that I last saw him alive on Oct 4 - 1922and that death occurred, on the date stated above, at 7-45 P m.

The CAUSE OF DEATH* was as follows:

Interstitial NephritisCONTRIBUTORY (Secondary) Arteriosclerosis(duration) Indefinite yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Caspell, M. D.10-6-1922 Address 611-N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Ambrose

20 UNDERTAKER

Samuel Hensley Biddle

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 17 WARD)2-FULL NAME Arthur Richardson(a) RESIDENCE NO. 1204 Druid Hill ave. ST. _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced
HUSBANd of
(or) WIFEs of Jennie Richardson6 DATE OF BIRTH (month, day, and year) 18877 AGE Years Months Days If LESS than 1 day.....hrs. or min.
35

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)10 NAME OF FATHER Chas. Richardson11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)12 MAIDEN NAME OF MOTHER Rose Waters13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)14 Informant Hospital Records
(Address) M.T.H.15 OCT 8 - 1922 ROBERT R. KRAUTER
Registrar
Burial Permit 587REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6, 192217 I HEREBY CERTIFY, That I attended deceased from July 15, 1922, to Oct. 6, 1922.that I last saw him alive on Oct. 6, 1922.and that death occurred, on the date stated above, at 6.25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 6 mos. ds.CONTRIBUTORY Tuberculous enteritis
(Secondary)(duration) yrs. 2 mos. ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? NO Date of _____

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray(Signed) Frank J. Adolph, M. D.10-6-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS 303

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

5 mos.

29 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Paul Brooks

6 DATE OF BIRTH (month, day, and year)

1869-

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Lancaster County

10 NAME OF FATHER

Addison Verie

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Lancaster Co.

12 MAIDEN NAME OF MOTHER

Eliza Verie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Lancaster Co.

14

Informant (Address)

Paul Brooks, 912 Whitcomb St.

15

00718-1922

ROBERT R. KNAUTH

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/6

1922

17 I HEREBY CERTIFY, That I attended deceased from June 24th 1922, to Oct 6th 1922,that I last saw him alive on Oct 5th 1922,

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis (acute)

(duration) yrs. 10 mos. ds.

CONTRIBUTORY Acute Nephritis (Secondary) (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) J. S. Edw. Bell, M. D.

19 (Address) 1247 Belmar St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Monica's Lancaster Co. Oct 9 1922

20 UNDERTAKER ADDRESS 1303

James A. Lewis, Thurman

N. B.—WHILE FILLING OUT THIS FORM, PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68152

D 68152

CERTIFICATE OF DEATH.

129

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N Washington ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Margareth Marie

(a) RESIDENCE NO.

1225 N Washington

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 3 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7, 19007 AGE Years 22 Months 3 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

John Marie

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Margarith Behr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

PARENTS

14 Informant (Address)

Margarith Marie
1225 N Washington15 8878-1922

ROBERT R. RAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1922I HEREBY CERTIFY That I attended deceased from Oct 1, 1922 to Oct 6, 1922that I last saw him alive on Oct 6, 1922and that death occurred, on the date stated above, at 10:10 P.M.

The CAUSE OF DEATH* was as follows:

Chorea Intermittens(duration) 1 yrs. 3 mos. 29 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 3 mos. 29 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Chorea(Signed) John Insley, M. D.19 (Address) 2738 E 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALHoly Redeemer Ceme

DATE OF BURIAL

Aug 10 1922

20 UNDERTAKER

John Dellerich

ADDRESS

2008 E 3rd St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rhs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68153

CERTIFICATE OF DEATH.

92

D 68153

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 S. Linwood ST., 1 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sophie Landon

(a) RESIDENCE NO.

706 S. Linwood

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

husband of

(or) wife of

Samuel R Landon

6 DATE OF BIRTH (month, day, and year)

10/13/1893

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

28

11

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Conrad Fenger

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Huboch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Memphis Tenn

14

Informant (Address)

Sam R. Landon
706 S. Linwood

15

OCT 8 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6 19 22

17

I HEREBY CERTIFY, That I attended deceased from Oct 6, 19 22, to Oct 6, 19 22,

that I last saw him alive on Oct 6, 19 22,

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. E. Schneider, M. D.

10/6, 1922 (Address) 24039 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oaklawn

DATE OF BURIAL

Oct 9 19 22

20 UNDERTAKER

Fiskler & Fiskler

ADDRESS

1739 Eager

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "*Laborer*," "*Foreman*," "*Manager*," "*Dealer*," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*As far as physician
could determine, no other
cause.*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 68155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68155

74-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 130 W. Fort Ave. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *Janett W. Hancock*

(a) RESIDENCE (No. 130 W. Fort Ave)

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Anna C. Hancock

6 DATE OF BIRTH (month, day, and year) *May 17, 1850*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
72 4 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fisherman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Anna Brunel Co., Md.*

10 NAME OF FATHER *Janett W. Hancock, Sr.*

11 BIRTHPLACE OF FATHER (city or town) *a. a. Co., Md.*

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town) *Not known*

14 Informant *Wm. S. Hancock*
(Address) *130 W. Fort Ave*

15 *OCT 8 - 1922* *HUBERT R. MAUTER*
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 8 1922*

17 I HEREBY CERTIFY, That I attended deceased from

Oct 3, 1922, to Oct 8, 1922,

that I last saw him alive on *Oct 7, 1922,*

and that death occurred, on the date stated above, at *2:30 A. m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) *Exhaustion*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. L. Hancock, Jr., M.D.*

(Address) *1644 Hancock St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Int. Carmel Cemetery

DATE OF BURIAL

Oct. 10 1922

20 UNDERTAKER

Girkler + Girkler

ADDRESS

1739 E. Eager St.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68156

D 68156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. ...)

2-FULL NAME

(Residence in Baltimore: No. ...)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., 12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,
M

4-COLOR OR RACE,
W

5-Single,
Married, Married
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH.

Nuknow

1890

(Month)

(Day)

(Year)

7-AGE.

32

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Talor

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country).

Lithvania

10-NAME OF FATHER.

John Zablackas

11-BIRTHPLACE OF FATHER.

(State or Country).

Lithvania

12-MAIDEN NAME OF MOTHER.

Nuknow

13-BIRTHPLACE OF MOTHER.

(State or Country).

Lithvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annele Zablackas

(Address) 705 W Lombard Street

15-

File

OCT 8 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Oct.

7

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said

inquest, au-

topsy, or inquiry, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Eye Poisoning
Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Burton, M. D.

(Coroner)

19- (Address) 437 E. Eway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the

State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Holy Redeemer

Oct. 9th 1922

20-UNDERTAKER.

ADDRESS

John Grebliauckas, 425 S Paca St.

D 68157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Homewood Hospital ST., 3 WARD)

2-FULL NAME

Edith J. Bevans

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

3622 Roland Ave. ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND OF
(or) WIFE ofMummill Bevans

6 DATE OF BIRTH (month, day, and year)

April 26, 1896

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.26510

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Govanstown
Baltimore

10 NAME OF FATHER

Charles F. Bontner

11 BIRTHPLACE OF FATHER (city or town)

York Co.
Penna.

12 MAIDEN NAME OF MOTHER

Amelia Miller

13 BIRTHPLACE OF MOTHER (city or town)

Chester
Pa.

14

Informant
(Address)Markel Martin
310 E. Randall St.

15

Filed OCT 8-1922ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 6 1922

17

HEREBY CERTIFY, That I attended deceased from

Oct 3, 1922, to Oct 6, 1922that I last saw her alive on Oct 6, 1922and that death occurred, on the date stated above, at 8:25 A. M.

The CAUSE OF DEATH* was as follows:

appendicitis(duration) yrs. mos. 2 ds.CONTRIBUTORY Ch. Valvular Heart.
(Secondary)(duration) 8 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? HomeDid an operation precede death? yes Date of Oct 5, 1922Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frederick H. Hoff, M. D.Address 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

London Park

UNDERTAKER

Horace H. Burgee

DATE OF BURIAL

Oct 9, 1922

ADDRESS

7631 Hall Rd

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68158 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68158

1-PLACE OF DEATH

City of BALTIMORE: (No. 424 N. Washington St. 6 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 424 N. Washington St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

Single,
Married,
Widowed,
or Divorced.
(Write the word.)

6-DATE OF BIRTH

July 24 1857

7-AGE

65 yrs. 7 mos. 13 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

Balto md

10-NAME OF FATHER

Chas. H. Whitford

11-BIRTHPLACE OF FATHER,
(State or Country).

Hartford Co

12-MAIDEN NAME OF MOTHER

Eliza J. Marshall

13-BIRTHPLACE OF MOTHER,
(State or Country).

Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

FRI

OCT 8 - 1922

ROBERT R. KRAUTER,

Notary Public

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 5 or 6 1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Bicarbonate of Mercury

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Wadsworth M. D.

10-8 1922 (Address) 108 E. Lombard

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Abingdon (Hartford Co) Oct 9 1922

20-EMERALTAKER

ADDRESS

Horace H. Burgee 3631 Falls Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68159

CERTIFICATE OF DEATH.

D 68159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 W. 33 St

ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William F Evert

(a) RESIDENCE. NO. 600 W. 33 St

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. - mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Elizabeth J Evert

6 DATE OF BIRTH (month, day, and year) Sept 4 1870

7 AGE Years 52 Months 1 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C. (State or country)

10 NAME OF FATHER Charles E Evert

11 BIRTHPLACE OF FATHER (city or town) Sweden (State or country)

12 MAIDEN NAME OF MOTHER Mary E Calder

13 BIRTHPLACE OF MOTHER (city or town) Hartford, Co. (State or country)

14 Informant (Address) Mrs Elizabeth Evert 600 W. 33 St

15 OCT 8 - 1922

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 29 1922, to Oct 6 1922,

that I last saw him alive on Oct 6 1922,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Large brain hemorrhage left side of brain Progressive Paralysis of right side

(duration) yrs. mos. ds. 7

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) R. B. Norman M. D.

10.7.19 Address 3347 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 DATE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Oct 9/22

20 ADDRESS

18 Marshall 3539 Fall Rd.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D. 68160

D. 68160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 Cedar Avenue ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Bull Phelps(a) RESIDENCE. No. 205 Cedar Avenue ST. 27 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Phelps6 DATE OF BIRTH (month, day, and year) 18527 AGE Years 70 Months 0 Days 0 If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Penn (State or country)10 NAME OF FATHER Henry11 BIRTHPLACE OF FATHER (city or town) don't know (State or country)12 MAIDEN NAME OF MOTHER don't know13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)14 Informant George L. Bull (Address) 205 Cedar Ave15 OCT 8-1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct - 5 192217 I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1922, to Oct - 5, 1922, that I last saw him alive on Oct - 5, 1922.and that death occurred, on the date stated above, at 10-00 P.M.

The CAUSE OF DEATH* was as follows:

StarvationCONTRIBUTORY (Secondary) Senile Dementia (duration) 12 yrs. 0 mos. 0 ds. + 2 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? —Did an operation precede death? No Date of —Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Libron Porter, M. D.10/7/22 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL WoodlawnDATE OF BURIAL Oct 9 192220 UNDERTAKER E. LeRoy StiffleeADDRESS 125 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68161

CERTIFICATE OF DEATH.

D 68161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

513 N. Castel

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jacob Nohe

(a) RESIDENCE. NO.

513 N. Castel

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary Hersteller

6 DATE OF BIRTH (month, day, and year)

April 21 1864

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

57

5

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Jacob Nohe

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)

Mary Nohe

513 N. Castel

15

Filed

19

OCT 8-1922

ROBERT R. KAUFER

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10-7

1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1 1922, 10-7, 1922
that I last saw him live on 10-6, 1922

and that death occurred, on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration
hypertension
(duration) yrs. 6 mos. 1 ds.CONTRIBUTORY
(Secondary)acute Myocardial Dilatation
(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted

if not at place of death?

unknown

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Findings

(Signed)

1922

Address

800 N. Wall St.
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Oct 10 1922

20 UNDERTAKER

ADDRESS

Wendell Dippel 180

378 N. Wall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68162

CERTIFICATE OF DEATH.

D 68162

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3101 Guyan Ave ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE No. 3101 Guyan Ave ST. 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of None6 DATE OF BIRTH (month, day, and year) Aug 27 18677 AGE Years 55 Months 7 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany12 MAIDEN NAME OF MOTHER Katharine Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14

Informant (Address) John G. Grebe

15

Filed Oct 18 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6 1922I HEREBY CERTIFY, That I attended deceased from Sept 23, 1922, to Oct 6, 1922.that I last saw him alive on Oct 5, 1922.and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None(Signed) M. B. Mannan Hood, M. D.19 2 (Address) 626 N. Gibson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 Burgundy ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margareth Smith

(a) RESIDENCE NO.

808 Burgundy St

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

William Smith

6 DATE OF BIRTH (month, day, and year)

7 AGE

about 67

Years

Months

Days

If LESS than 1 day, hrs. or min.

716

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Honey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Mrs Jennie Latta
808 Burgundy

15

Filed

OCT 8 1922ROBERT R. KRAUER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1922 to Oct 6 1922
that I last saw her alive on Oct 4 1922

and that death occurred, on the date stated above, at

2600 p.m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Arterio Sclerosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Oedema

(Signed)

Benjamin S. Bloom, M. D.

(Address)

1214 N. E. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

W. G. Lickner & Sons714 Pa

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 8-24-14-M. & T.-2000 Bks.

268164 HEALTH DEPARTMENT-CITY OF BALTIMORE 268164

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 811 N Payson St.; WARD 16)

2-FULL NAME
(Residence in Baltimore: No. 811 N Payson St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 27, 1874 (Month) (Day) (Year)

7-AGE 48 10 If LESS than 1 day, yrs. mos. ds. hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Clerk
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Alex Stoppa

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER, A. Wendenhoff

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. Seibert
(Address) 811 N Payson

15- OCT 8-1922 ROBERT N. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 7, 1912 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 21, 1912 to Oct 7, 1912, that I saw him alive on Oct 6, 1912, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Oedema of Lungs
Ch. Int. neph.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) J. S. D. L. D. Address 1126 W. 6th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, 10/9, 1912

20-UNDERTAKER, Wm. J. Tschertke ADDRESS, 1017 N. P. Ave.

state
PA-
PHYSICIANS should be stated EXACTLY. Exact statement of OCCASION
mation should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

(See Letter Attached)
068165 HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH. 31

068165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline (Kallenburg) Kallenbenz

(a) RESIDENCE No. 1607 Olive St ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of John Kallenbenz (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1854 1859
7 AGE Years 68 Months 63 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 OCT 8 - 1922 ROBERT A. KASULICH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept. 28 19 22 to October 5 19 22.
that I last saw her alive on October 5 19 22.
and that death occurred, on the date stated above, at 6 P.M. m.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) 10 yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis
(Secondary) (duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No - Reported

What test confirmed diagnosis? Physical X rays
(Signed) Clyde McKee M. D.

10/6/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Cedar Hill Cem. DATE OF BURIAL Oct. 9, 1922

20 UNDERTAKER Margaret Flynn ADDRESS 1427 Highland

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

GEORGE R. MCCLEARY,
SUPERINTENDENT
W. H. CURRY,
ASST. SUPERINTENDENT



BAY VIEW HOSPITAL

HIGHLANDTOWN P. O. , October 10, 1922

To Whom It May Concern:-

Pauline Kallenberg, was admitted to this hospital August 31, 1922 and again September 28, 1922. On the first admission she gave her age as 67, and on the second admission as 68. John Kallenberg, the husband, says that the correct age is 63. I have no personal knowledge of the age of this patient.

Clyde D. Neil
Resident Physician.

CMCN/MAH.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

268166

HEALTH DEPARTMENT—CITY OF BALTIMORE

268166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Proton...

Registered No. C.....

City of BALTIMORE: (No. Ward)

St. Joseph's Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Garrety

(Residence in Baltimore: No. St., yrs. mos. ds.)

Old Hayford Rd above Putney Hill

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White

Single
Married
Widowed
or Divorced.
(Write the word.)

6-DATE OF BIRTH,

Oct.

1st

1887

(Month)

(Day)

(Year)

7-AGE,

54

yrs.

4

mos.

4

ds.

IF LESS than 1 day,

hrs.

min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

R.R. Conductor

(b) General nature of industry, business, or establishment in which employed (or employer).

Caution York

9-BIRTHPLACE,

(State or Country),

Baltimore

PARENTS.

10-NAME OF FATHER,

John Garrety

11-BIRTHPLACE OF FATHER,
(State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER,

Unknown

13-BIRTHPLACE OF MOTHER,
(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Elizabeth Garrety

(Address)

Old Hayford Rd above Putney Hill

15-

OCT 8 - 1922 ROBERT R. KRAUTER

Filed

102

Burial Permit Clerk

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct

5

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an...
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said...

(Inquest, au-

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Thoracic Aneurysm

Crushed between cars

while working a coupling

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *John P. Patton* M. D.

(Coroner)

Oct 7 1922 (Address) *508 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. State....yrs....mos....ds.

In the

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Holy Redeemer Cemetery

Oct 9 1922

20-UNDETAILED

ADDRESS

George J. Ruth

1735 Hayford Av

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 Washington Boulevard ST. 14 WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

OCT 8 - 1922

ROBERT R. KRAUTER Registrar

Serial Permit Block

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 5 1922

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1922, to Oct 5, 1922, that I last saw him alive on Oct 4, 1922, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 4 yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Tests (Signed) J. M. Delaney M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

068168 HEALTH DEPARTMENT—CITY OF BALTIMORE 068168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. *Johns Hopkins Hsp* 13th St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Elizabeth Harrod*
(Residence in Baltimore: No. *816* *Hampson* St.; yrs. mos. ds.)

Registered No. C.....

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>Black</i>	5-Single, Married, Widowed, or Divorced. (Write the word.) <i>Married</i>	16-DATE OF DEATH. <i>Oct 7</i> , 192 <i>2</i> (Month) (Day) (Year)	
6-DATE OF BIRTH. 1..... (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>inquest</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>inquest</i> and that said deceased came to <i>death</i> (Inquest, autopsy or inquiry.) on the day stated above.	
7-AGE. <i>10 1/2</i> yrs. mos. ds. If LESS than 1 day, hrs. or min.?			The CAUSE OF DEATH* was as follows: <i>Broncho-pneumonia</i> <i>over</i> (Duration) yrs. mos. ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Child</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>not</i>			CONTRIBUTORY (Secondary) <i>not</i> (Duration) yrs. mos. ds.	
9-BIRTHPLACE. (State or Country). <i>Baltimore</i>			(Signed) <i>J. S. H. Baker</i> M. D. (Coroner.) <i>1018</i> 192 <i>2</i> (Address) <i>508 E. Pratt</i>	
PARENTS.	10-NAME OF FATHER. <i>Frank Harrod</i>	11-BIRTHPLACE OF FATHER. <i>W. Va.</i>	*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	12-MAIDEN NAME OF MOTHER. <i>Bertha Morris</i>	13-BIRTHPLACE OF MOTHER. <i>Balt.</i>	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.	
	14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Johns Hopkins Hsp</i> (Address)		Where was disease contracted, if not at place of death?	
	15- <i>OCT 9-1922</i> <i>ROBERT R. KRAUTER,</i> Filed 192 <i>2</i> <i>Bureau Permit Clerk</i> Registrar.		19-PLACE OF BURIAL OR REMOVAL. <i>Mc Auburn</i> DATE OF BURIAL. <i>Oct 10, 1922</i>	
			20-UNDERTAKER. <i>John H. Trading</i> ADDRESS <i>143</i>	

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Baltimore Md*
 CITY OF BALTIMORE: (No. *787 St Peter St.*)
 2-FULL NAME *Warren Hampton*
 (Residence in Baltimore: No. *787 St Peter St.*)

REGISTERED NO. C

ST. *21* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male.* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
 MARRIED, WIDOWED, OR DIVORCED.
 (Write the word.)
 6-DATE OF BIRTH, *July 13, 1922*
 (Month) (Day) (Year)
 7-AGE, *2 yrs. 2 mos. 23 ds.* If LESS than 1 day,
 hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work *none*
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 9-BIRTHPLACE, (State or Country), *Maryland*
 10-NAME OF FATHER, *John A. Hampton*
 11-BIRTHPLACE OF FATHER, (State or Country), *Maryland*
 12-MAIDEN NAME OF MOTHER, *Flora Lennard*
 13-BIRTHPLACE OF MOTHER, (State or Country), *Maryland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Florence Hampton*
 (Address) *787 St Peter St*

15-

OCT 9-1922

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *October 6, 1922*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *September 1922* to *Oct 6, 1922*,
 that I saw him alive on *Oct 6, 1922*,
 and that death occurred, on the date stated above, at *5 A* m.

The CAUSE OF DEATH* was as follows:

Malnutrition
 (Duration) yrs. *2* mos. ds.
 CONTRIBUTORY (Secondary) *none*
 (Signed) *W. A. Ingram* M. D.
Oct 7, 1922 (Address) *2439 N Charles*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Western*DATE OF BURIAL, *Oct 9, 1922*

20-UNDERTAKER

ADDRESS

John Fields 1200 N Lombard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68170

CERTIFICATE OF DEATH

D 68170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 725-10 Saratoga ST.: 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 725-10 Saratoga ST.: 11 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of 6 DATE OF BIRTH (month, day, and year) 10/7/227 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Joseph Gardini11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)12 MAIDEN NAME OF MOTHER Maria Liberto13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)14 Informant Joseph Gardini (Address) 15-10 Saratoga15 Filed Oct 9-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/7/2217 I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1922, to Oct. 7, 1922, that I last saw him alive on Oct. 7, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Was there an autopsy? noWhat test confirmed diagnosis? (Signed) Thos. E. Blaback M. D. (Address) 1014 W. La Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 10/9/2220 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harbor Ave

Cause of death should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68171

CERTIFICATE OF DEATH.

D 68171

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 Morris ST., 19 WARD)

2-FULL NAME Frank A. Horvath

(a) RESIDENCE NO. 411 Morris

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 9

mos. 24

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 13 = 1912

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min. 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

10 NAME OF FATHER Frank A. Horvath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago Ill.

12 MAIDEN NAME OF MOTHER Angel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Chicago Ill.

14

Informant (Address) 411 Morris St.

15

Filed 3861-51305 - ROBERTSON, MONTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7, 1922.

17

HEREBY CERTIFY, That I attended deceased from Oct. 1, 1922, to Oct. 7, 1922. that I last saw him alive on Oct. 6, 1922.

and that death occurred, on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

CONTRIBUTORY (Secondary) Gout Intestine (duration) yrs. mos. ds. 7

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Clinical finding

(Signed) James H. Cunningham, M.D.

19 PLACE OF BURIAL, CREMATION OR RE-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

20 UNDERTAKER

ADDRESS

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

411 Morris St.

D 68172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68172

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *107 S. Butler*)ST.: *2* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *107 S. Butler*)St.: *15* yrs., *—* mos. *—* ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Benj. Leverton*(Address) *107 S. Broadway*15- *OCT 9-1922*

ROBERT K. RAUTER,

Filed *191*

191

Burlingame, Pa.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 14 19*22*, to *Oct 9* 19*22*,
that I saw her alive on *Oct 8* 19*22*,and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH* was as follows:

*Heart failure**(Duration) yrs. mos. ds.*CONTRIBUTORY
(Secondary)*Hypertension, nephritis*
(Duration) yrs. mos. ds.(Signed) *Robert K. Rauter* M. D.*Oct 9* 19*22* (Address) *107 S. Broadway*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Hebrew Burial *Oct 7, 1922*

20-UNDERTAKER

ADDRESS

Map *177 E. Baltimore St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1032 N. Payson St.

ST.: 16 WARD)

2-FULL NAME Thelma P. Dittmar

(a) RESIDENCE. No. 1132 N. Payson
(Usual place of abode)

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. 3 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Dittmar

6 DATE OF BIRTH (month, day, and year) July 27, 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md.

10 NAME OF FATHER Robert Dittmar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md.

12 MAIDEN NAME OF MOTHER Josephine Herd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt Md.

14 Informant Robert Dittmar
(Address) 633 N. Payson St.

15 Filed 1922 ROBERT A. KAUFER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1922, to Oct 7, 1922.

that I last saw her alive on Oct 7, 1922.

and that death occurred, on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Acute meningitis over
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyd M. D.

7-12-1922 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cemetery Oct 9 1922

20 UNDERTAKER ADDRESS

Geo Leimbach & Son 847 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably*, such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Simple

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68174

CERTIFICATE OF DEATH.

D 68174

1-PLACE OF DEATH *Hebrew Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST. *3* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Sarah Goodman*

(a) RESIDENCE: NO.

216 S. Eden St.

ST.

WARD.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *30* yrs.

mos.

ds.

How long in U. S., if of foreign birth? *30* yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Abraham Goodman*

6 DATE OF BIRTH (month, day, and year)

1876

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*46*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Housewife*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Russia*

10 NAME OF FATHER

Wolf Gott

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Gott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant

(Address)

*Jack Lewis
1439 E. Balt St*

15

*Filed
Oct 9 - 1922*

ROBERT R. KRAUTER

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*10/7*19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*September 12, 1922, to Oct. 7, 1922.*that I last saw him alive on *Oct 7, 1922.*and that death occurred, on the date stated above, at *5:45 A.M.*

The CAUSE OF DEATH* was as follows:

Myocardial Infarction;

(duration)

yrs.

mos.

10

ds.

CONTRIBUTORY
(Secondary)*Lobar Pneumonia*

(duration)

yrs.

mos.

23

ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

Moses Seltman

, M. D.

10/7, 19

(Address)

Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebrew Wash Road**10/9*19 *22*

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Balt St

Information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68175

CERTIFICATE OF DEATH.

D 68175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Linden Ave ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Lyne

(a) RESIDENCE. No. 1209 Linden Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female white

Single

5a If married, widowed, or divorced, HUSBAND of (or WIFE of)

6 DATE OF BIRTH (month, day, and year)

7 AGE

66

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

No occupation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Mary Ann Lyne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mary land

12 MAIDEN NAME OF MOTHER

Elizabeth Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mary land

14

Informant (Address)

The Nurses, 1209 Linden Ave

15

OCT 9-1922

ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7th 1922

17

I HEREBY CERTIFY, That I attended deceased from March 1922, to Oct 7th 1922, that I last saw him alive on October 7, 1922, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Mammary Carcinoma.

CONTRIBUTORY (Secondary)

(duration) yrs. 9 mos. ds. Hypostatic Pneumonia

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alira Palleck, M. D.

19 (Address) 1112 Eutan St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem

10-9 1922

20 UNDERTAKER

ADDRESS

George A. E. Simpson & Co

McCallister & Co

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68176

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68176

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *4* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mr. L. Fertita*

(Residence in Baltimore: No. *762 Redwood St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. *Single*

6-DATE OF BIRTH *May 10 1920*

7-AGE *2 yrs. 4 mos. 27 ds.* IF LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country) *Bapt City*

10-NAME OF FATHER *Anthony Fertita*

11-BIRTHPLACE OF FATHER (State or Country) *Italy*

12-MAIDEN NAME OF MOTHER *Esther Jones*

13-BIRTHPLACE OF MOTHER (State or Country) *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Anthony Jones*
(Address) *726 Redwood St*

15- *OCT 9 - 1922*

ROBERT R. KRAUTER,

Filed

192

Burial Permit *Black*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Oct 7 1922*

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest* ~~autopsy~~ inquiry, thereon and from the evidence obtained by said ~~inquest~~ *inquiry*, and that said deceased came to *this* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & injuries to chest

CONTRIBUTORY *Struck by Auto Truck*

(Signed) *W. H. Gorman* M. D. (Coroner.)

10-7-1922 (Address) *117 W. Saratoga St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, ... yrs. mos. ds. In the State, ... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Louisa Park* DATE OF BURIAL *Oct 9 - 1922*

20-UNDERTAKER *H. B. Brunning Son* ADDRESS *517 N. Schroeder St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68177

D 68177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *522 Orchard* ST. *17* WARD)2-FULL NAME *Mary Anderson*(a) RESIDENCE NO. *522 Orchard* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *29* yrs. *2* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *Black*5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 1893*

7 AGE

Years *29*Months *2*Days *—*

If LESS than day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto Md*
(State or country)10 NAME OF FATHER *John Anderson*11 BIRTHPLACE OF FATHER (city or town) *Frederick Md*
(State or country)12 MAIDEN NAME OF MOTHER *Mattie Wormley*13 BIRTHPLACE OF MOTHER (city or town) *Pa*
(State or country)

14

Informant *Grace Anderson*
(Address) *522 Orchard*

15

Filed *0879-1922*ROBERT R. KRAUTER,
Registrar

Burlal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 6 - 1922*17 I HEREBY CERTIFY, That I attended deceased from *Paley*, 1921, to *Oct 6th*, 1922.
that I last saw her alive on *Oct 6*, 1922.and that death occurred, on the date stated above, at *2:30 P.* m.

The CAUSE OF DEATH* was as follows:

Subdural Hepatitis(duration) *1* yrs. *7* mos. ds.CONTRIBUTORY *General Anemia*
(Secondary)(duration) yrs. mos. *10* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Gustav Goldman*, M. D., 19 (Address) *556 W Franklin*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

MT Auburn An

20 UNDERTAKER

Daniel Easton

DATE OF BURIAL

*Oct 9 1922*ADDRESS *916**Be an*

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Rev.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68178

CERTIFICATE OF DEATH.

D 68178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 W. 36th ST. 13 WARD)

2-FULL NAME Wm. A. Braumer

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1510 W. 36th ST. WARD (Usual place of abode) (If non-resident give city or town and State) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Child 5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single 6 DATE OF BIRTH (month, day, and year) Jan 19, 1922 7 AGE Years Months Days If LESS than 1 day, hrs or min. 9 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

10 NAME OF FATHER Wm B Braumer

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Susan Covey

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Wm B Braumer (Address) 1510 W 36th St

15 Filed 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1922, to Oct 8, 1922, that I last saw him alive on Oct 8, 1922, and that death occurred, on the date stated above, at 6:20 P.M. The CAUSE OF DEATH* was as follows:

Exhaustion malnutrition

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) Malaria (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of Jan 8

Was there an autopsy? no

What test confirmed diagnosis? Ross J. H. (Signed) Ross J. H. (Address) 2705 Fall Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

St Marys Hospital Oct 16, 1922

20 UNDERTAKER ADDRESS Chenoweth & Son Chestnut St

D 68180

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *13* ST. *13* WARD)

2-FULL NAME

Baby Mullen

(a) RESIDENCE NO.

2249 Brem Ave.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred

yrs.

mos.

2

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 5, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Jermey Mullen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Maryland

12 MAIDEN NAME OF MOTHER

Albina Naylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

J. J. Mullen

15

Filed

19

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 7 - 1922

17

I HEREBY CERTIFY, That I attended deceased from *Oct 5*, 1922, to *Oct 7*, 1922.that I last saw him alive on *Oct 7*, 1922.and that death occurred, on the date stated above, at *10:10 P. m.*

The CAUSE OF DEATH* was as follows:

*Acute suppression of urine.**Never voided from birth.*(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes (partial)*

What test confirmed diagnosis?

(Signed) *George E. Shanner*, M. D.19 (Address) *Md. General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAT

Holy Redeemer

20 UNDERTAKER

M. Tracy Son

DATE OF BURIAL

Oct 9 1922

ADDRESS

1822 W. North

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68181HEALTH DEPARTMENT—CITY OF BALTIMORE **D 68181**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2111 Herbert St. ST. 15 WARD)2-FULL NAME William Stanley Arbough.(a) RESIDENCE. NO. 2111 Herbert St. ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
 1 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)10 NAME OF FATHER Robert Arbough11 BIRTHPLACE OF FATHER (city or town) Balto, Md.
(State or country)12 MAIDEN NAME OF MOTHER William Lover13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)14 Informant Robert Arbough(Address) 2111 Herbert St.**OCT 9-1922** H. A. C. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7. 19 22

17 I HEREBY CERTIFY, That I attended deceased from

Oct 6/22 19 22, to Oct 7 19 22,that I last saw him alive on Oct 6 19 22,and that death occurred, on the date stated above, at 1:45 P.m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum(duration) yrs. 2 mos. ds.CONTRIBUTORY
(Secondary)Cordae Paras(duration) yrs. 1 mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of noneWas there an autopsy? noneWhat test confirmed diagnosis? none(Signed) G. W. A. Fetherhoff M. D., 19 (Address) 1807 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery Oct 9 19 22

20 UNDERTAKER

ADDRESS

Martin Hughes & Sons. 1821 W North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68182

CERTIFICATE OF DEATH.

D 68182

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 N. Caroline ST., 9 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1812 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

James E. McIntire

6 DATE OF BIRTH (month, day, and year) Aug 29-1841

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

81 - 1 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

OCT 9-1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1922

17 HEREBY CERTIFY, That I attended deceased from

Oct 4, 1922, to Oct 7, 1922,

that I last saw him alive on Oct 7, 1922,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Kirby, M. D.

19 22 Address 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Mrs M. Gaultrope

DATE OF BURIAL

Oct 10 1922

ADDRESS

2589 Rayner Ave

tion should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

✓ Mrs Frank Kirby
1010 E North Ave

100-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68183

D 68183

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 712 S. Green ST. 22 WARD)2. FULL NAME Ruth English(a) RESIDENCE NO. 712 S. Green ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 9

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female Col.

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of L6 DATE OF BIRTH (month, day, and year) Mar 7 1921

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.1629

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)S. C.10 NAME OF FATHER Jessie J. English11 BIRTHPLACE OF FATHER (city or town)
(State or country)S. C.12 MAIDEN NAME OF MOTHER Sadie Sunday13 BIRTHPLACE OF MOTHER (city or town)
(State or country)S. C.

14

Informant
(Address)Jessie English
712 S. Green St

15

Filed

Oct 9 - 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 4th 1922 to Oct. 6th 1922that I last saw her alive on Oct 6th 1922and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(duration) 2 yrs. 3 mos. 3 ds.CONTRIBUTORY
(Secondary)(duration) 1 yrs. 1 mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of LWas there an autopsy? noWhat test confirmed diagnosis? General signs
(Signed) D. H. Lunnell M. D.19 PLACE OF BURIAL, CREMATION OR RE-MOVAL
(Address) 1406 W. Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Int. auburn burOct 9, 1922

20 UNDERTAKER

ADDRESS

Mrs Geo H. Hooper 406 W. Broadway

mation should be carefully supplied. AGE should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

63
D 68184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D 68184

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1105 S. Streeper

ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rosa Bollack

(a) RESIDENCE. NO.

1105 S Streeper

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

Peter Bollack

6 DATE OF BIRTH (month, day, and year)

Nov. 4 - 1859

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

62

10

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

H. W.

9 BIRTHPLACE (city or town) (State or country)

Richmonds Va

10 NAME OF FATHER

Peter Bollack

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary Bender

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant

(Address)

Peter Bollack

1105 S. Streeper St.

15

OCT 9 - 1922

ROBERT A. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-6 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 6 1922, to Oct 6 1922.

that I last saw her alive on Oct 6 1922.

and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTOR (duration) yrs. mos. ds.

Chronic Valvular Heart Disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. B. Bromberg M. D.

(Address) 3037 Odumell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

First Evangelical Cemetery Oct 10 1922

20 UNDERTAKER

ADDRESS

H. Vander & Sons 1710 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Moniewski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68185

CERTIFICATE OF DEATH.

D 68185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 832 S Kenwood ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Infant still birth of Paul Mary Moniewski*

(a) RESIDENCE NO. 832 S Kenwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 8 1922*

7 AGE Years Months Days If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Paul Moniewski*11 BIRTHPLACE OF FATHER (city or town) *Poland* (State or country)12 MAIDEN NAME OF MOTHER *Mary Barbowicz*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)14 Informant *Paul Moniewski* (Address) *832 S Kenwood*15 Filled *ROBERT R. MAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 8 1922*17 I HEREBY CERTIFY, that I attended deceased from *Oct 8 1922* to *Oct 8 1922* that I last saw him alive on *Oct 8 1922*and that death occurred, on the date stated above, at *m.*

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *A. J. Thompson* M. D.(Address) *801 Monmouth*

*State the Disease Causing Death, or in deaths from Violent Causes, the (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Holy Roodery**Oct 9 1922*

20 UNDERTAKER

ADDRESS

*John M. Weber**1803 Bank*

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68186

CERTIFICATE OF DEATH.

D 68186

1-PLACE OF DEATH

Bn Secura Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST. 18

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Michael J. Sullivan

(Residence in Baltimore: No.

933 W Lombard St

St. 40 yrs., 7 mos., 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

married

6-DATE OF BIRTH,

September 5, 1879

7-AGE,

43 yrs., 1 mos., 2 ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Boiler maker
BROKER

9-BIRTHPLACE,

(State or Country),

Ireland

10-NAME OF FATHER,

John Sullivan

11-BIRTHPLACE OF FATHER

(State or Country),

Ireland

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER

(State or Country),

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

Mrs. Mary J. Sullivan

(Address),

933 W Lombard St

15-

OCT 9 - 1922

ROBERT R. MAUTER

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

October 7, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 7, 1922, to Oct 7, 1922

that I saw him alive on Oct 7, 1922,

and that death occurred, on the date stated above, at 10 am.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY

(Secondary)

Postoperative gastro-intestinal

(Signed).....M. D.

Oct 7, 1922 (Address).....Bn Secura Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

New Cathedral Cemetery Oct 10, 1922

20-UNDERTAKER

ADDRESS

John J. Cowan & Louis Holm
Rev. J. J. Cowan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D 68187

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2146 Bayd

ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Anna May Young

(a) RESIDENCE, No. 2146 Bayd

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 1 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (Write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

none

6 DATE OF BIRTH (month, day, and year)

Aug. 15-1903

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

19

1

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Candy Factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

William J. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Carnell B. Md.

12 MAIDEN NAME OF MOTHER

Lottie Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant

(Address)

William J. Young
2146 Bayd Rd

15

Filed

OCT 9-1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 6-1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 6, 1922, to Oct 7, 1922,

that I last saw her alive on Oct 7, 1922,

and that death occurred, on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death?

Date of

Was there an autopsy?

none

What test confirmed diagnosis?

Clinical diagnosis

(Signed) E. Heller, M. D.

Address 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudin Park Cemetery

Oct. 9th 22

20 UNDERTAKER

ADDRESS

George L. Schwab, 2101 Fredk. Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCASION CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 68188

CERTIFICATE OF DEATH

129 D 68188

PLACE OF DEATH

CITY OF BALTIMORE (No.

1230 Main

ST. 25 WARD

FULL NAME

Maggie A. Wood

(Residence in Baltimore: No.

1230 Main

Str.: 3 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH July 16, 1852 (Month) (Day) (Year)

7 AGE 70 yrs. 7 mos. 20 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

Home

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER Thomas Murray

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Geo Walter Towner

(Address)

1319 Main st

15

Filed

OCT 9 - 1922

ROBERT R. MAUTER, REGISTRAR

Barial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 6, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from Oct 3, 1922 to Oct 6, 1922

that I saw her alive on Oct 5, 1922

and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Reflux

Contributory (SECONDARY) uremia

(Signed) Geo. W. Kieffer M. D. Oct 6, 1922 (Address) 2320 Wood St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Loudon Park Cemetery Oct. 9th 1922

20 UNDERTAKER ADDRESS

George L. Schwab 2101 Fredk. Ave

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 68189

CERTIFICATE OF DEATH

D 68189

PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. *1702 Bolton*

ST. *14* WARD)

FULL NAME *Edward Wischmayer*

(Residence in Baltimore: No. *1702 Bolton St.*

St. *63* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *widowed* (Write the word)

6 DATE OF BIRTH *Sept 12, 1843* (Month) (Day) (Year)

7 AGE *79* yrs. *25* mos. ds. or min. ? If LESS than 1 day, hrs.

8 OCCUPATION (a) Trade, profession, or particular kind of work *Tobacco* (b) General nature of industry, business, or establishment in which employed (or employer) *045*

9 BIRTHPLACE (State or country) *Germany*

10 NAME OF FATHER *Edward Wischmayer*

11 BIRTHPLACE OF FATHER (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Doris Krum*

13 BIRTHPLACE OF MOTHER (State or country) *Germany*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Miss Wischmayer*

(Address) *1702 Bolton St.*

15

Filed *3361-6100* *ROBERT R. MAUTER* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 7, 1922* (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from *1919*, 191 to *Oct 7*, 1922 that I saw him alive on *Oct 7*, 1922 and that death occurred, on the date stated above, at *2:50 P* m. The CAUSE OF DEATH* was as follows:

Acute Cordiac Dilatation

Contributory (SECONDARY) *General Arteriosclerosis* (Duration) *1* yrs. mos. ds.

(Signed) *Stanley M. Mabley* M. D. *Oct 9, 1922* (Address) *1609 Linden Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *in the* yrs. mos. ds. State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Ludon Park Cem* DATE OF BURIAL *Oct 9, 1922*

20 UNDERTAKER *Chas. E. Frank* ADDRESS *802 Madison St.*

D 68190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 68190

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1709 N. Carolin ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Millard F. Horner

(a) RESIDENCE No. 1709 N. Carolin

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 11 = 1856

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 65 11 26

8 OCCUPATION OF DECEASED Financier

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Gatow Horner

11 BIRTHPLACE OF FATHER (city or town) Carroll Co. Md (State or country)

12 MAIDEN NAME OF MOTHER Sarah Gardner

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co. Md (State or country)

14 Informant Miss Nellie Gorman (Address) 1527 N. Caroline St.

15 Filed OCT 9 - 1922 ROBERT M. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1922, to Oct 7, 1922,

that I last saw him alive on Oct 7, 1922,

and that death occurred, on the date stated above, at 11:25 a. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart following acute Indigestion

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 36 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. O. Gorman, M. D.

10-7, 1922 (Address) 1709 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park

Oct 11 1922

20 UNDERTAKER

ADDRESS 1203

Henry Lutz N. Broadway

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

CERTIFICATE OF DEATH.

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(2) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.
-----	---	------	------	-----

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 7 1942

HEREBY CERTIFY, That I attended deceased from

and that death occurred, on the date stated above, at 251 13

The CAUSE OF DEATH* was as follows:

7 AGE	Year	Months	Days	If LESS than
-------	------	--------	------	--------------

1875

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

FILED OCT 9 - 1922 ROBERT H. NAUPEL

(duration) 2 yrs. 7 mos 41 ds

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. d

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death?.....Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) _____, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

John N.Y.

UNDERTAKER

Wm. H. Burleigh

DATE OF BURIAL

970

ADDRESS

Yours truly,

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68192

CERTIFICATE OF DEATH.

90 D 68192

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 Eagle

ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1830 Eagle

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs 8 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 6 - 1888

7 AGE Years 34 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

OCT 9 - 1922

ROBERT H. MAUTER

Bural Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 6. 1922

17 HEREBY CERTIFY, That I attended deceased from Sept. 20, 1922 to October 6, 1922

that I last saw him alive on Oct. 6, 1922.

and that death occurred, on the date stated above, at 7:55 p. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ☒ Date ofWas there an autopsy? ☒

What test confirmed diagnosis?

(Signed)

10-7, 1922 Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery

Oct. 10 1922

20 UNDERTAKER

ADDRESS

William Schaeffer

18th Monument

maison should be carefully supervised. All deaths should be reported to the Health Department. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 68193

CERTIFICATE OF DEATH

D 68193

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 1842 Hartford Ave. ST. 9 WARD)

2-FULL NAME Grace Viola Wolfe

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1842 Hartford Ave. St. 37 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married

16-DATE OF DEATH October 6, 1922 (Month) (Day) (Year)

6-DATE OF BIRTH Sept 6, 1885 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from October 2, 1922 to October 6, 1922

7-AGE 37 yrs. 4 mos. 0 ds. If LESS than 1 day, hrs. or min.?

that I saw her alive on October 6, 1922 and that death occurred, on the date stated above, at m.

8 OCCUPATION (a) Trade, profession, or particular kind of work Home work (b) General nature of industry, business, or establishment in which employed (or employer) Wife 131

The CAUSE OF DEATH* was as follows:

Acute Infectious Cholecystitis

9-BIRTHPLACE (State or country) Ind.

(Duration) yrs. mos. ds

10-NAME OF FATHER David Trimmer

Contributory (SECONDARY) (Duration) yrs. mos. ds.

11 BIRTHPLACE OF FATHER (State or country) Pa.

(Signed) H. B. Bruckner M. D. October 6, 1922 (Address) 1378 S. Charles St.

12 MAIDEN NAME OF MOTHER Mary J. Jones

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

13 BIRTHPLACE OF MOTHER (State or country) Ind.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

At place of death yrs. mos. ds. In the State yrs. mos. ds.

(Informant) John W. Wolfe (Address) 1842 Hartford Ave.

Where was disease contracted? If not at place of death?

Former or usual residence

15- OCT 9-1922 ROBERT R. WALTER REGISTRAR

19-PLACE OF BURIAL OR REMOVAL Date of Burial Oct 10, 1922

20-UNDERTAKER W. M. Rountree ADDRESS 2235 N. North Ave.

D 68194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68194

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 845 W. North Ave., ST. 14 WARD)

2. FULL NAME Florence Esteria Harcourt Wynants

(a) RESIDENCE NO. 845 W. North Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr 29 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5 mos.

5 mos.

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Charles Wynants

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

France

12 MAIDEN NAME OF MOTHER

Kate Harcourt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant

(Address)

Mrs Chas. Wynants

845 W. North Ave.

15

OCT 9 - 1922

ROBERT R. MAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept-29 1922 to Oct. 7 1922

that I last saw her alive on Oct. 7 1922

and that death occurred, on the date stated above, at 10¹⁵ P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration)

yrs.

mos

6 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No

Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

R. S. Williamson, M. D.

(Address)

Raspburg, Balt., Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park Cemetery Oct 9 1922

Chas. Evans & Son 1801 N. Royal Ave

nation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 68195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68195

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 St. Anne ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 1610 St. Anne ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long is U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6 19227 AGE Years Months Days If LESS than 1 day, hrs. or min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER Andrew Norman11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston, Mass.12 MAIDEN NAME OF MOTHER Elizabeth Winsor13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia14 Informant (Address) Frank L. Norman15 OCT 9-1922 ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 192217 I HEREBY CERTIFY, That I attended deceased from Oct 6, 1922, to Oct 8, 1922.that I last saw her alive on Oct 8, 1922.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

This was a six month fetus whose premature birth was caused mother fasting (duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred C. Jewett, M. D. , 19 (Address) 2516 Penn. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Physicians should state Exact statement of OCCUPATION. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 68196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68196

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.,

WARD

Length of residence in city or town where death occurred 43 yrs. mos. ds.

How long in U. S., if of foreign birth? 73 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jola Prybylski.

6 DATE OF BIRTH (month, day, and year)

1873

7 AGE

49

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

3361-6100

ROBERT R. MAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7-22

17

I HEREBY CERTIFY, That I attended deceased from

OCT-2, 1922, to OCT-7, 1922.

that I last saw him alive on OCT 7, 1922.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue & lower jaw, with metastases to neck.

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic sections

(Signed) J. Buckner Jones M. D.

, 19 (Address) Bay View Hosp

*State the Disease Causing Death, (or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Stanislaus.

DATE OF BURIAL

Oct 10, 1922.

20 UNDERTAKER

M. F. Sadowski.

ADDRESS

405 S. Am

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68197.

CERTIFICATE OF DEATH.

D 68197.

1-PLACE OF DEATH

University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No

Lombard & Greene

ST. 5

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jane Hutchins

(a) RESIDENCE. NO.

Friendship Maryland.

WARD.

Friendship Maryland.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed

or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

John Thomas Hutchins

6 DATE OF BIRTH (month, day, and year)

Oct. 1839

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 3 years

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housewife.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Maryland.

(State or country)

10 NAME OF FATHER

Thomas Owens.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland.

12 MAIDEN NAME OF MOTHER

Saddie Woods.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland.

14

Informant

(Address)

M. L. Hutchins
Friendship, Md.

15

Filed

OCT 9 - 1922

ROBERT R. MAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10-8

19 22

17

I HEREBY CERTIFY, That I attended deceased from
Sept. 4 - 1922, to Sept. 8, 1922,
that I last saw her alive on September 8, 1922,
and that death occurred, on the date stated above, at 11:08 P. m.

The CAUSE OF DEATH* was as follows:

Uremia -

(duration)

yrs.

mos.

24 hrs

CONTRIBUTORY
(Secondary)Primary Carcinoma of gall bladder
and metastases

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Friendship Md.

Did an operation precede death?

yes

Date of 10-6-22.

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical findings.

(Signed)

W. J. Jones

M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Friendship A. A. Co

Oct 11,

19 22

20 UNDERTAKER

ADDRESS

Harry H. Witzke

1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68198

D 68198

1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D 68198

Registered No. C.....

City of BALTIMORE: (No. 1020 M^c Culloch St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Enguene Alexander

(Residence in Baltimore: No. 1820 M^c Culloch St. yrs. 7 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

colored

5-Single, Married, Widowed, or Divorced, (Write the word.)

Single

6-DATE OF BIRTH

Feb. 9, 1922

7-AGE

7 mos. 30 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

Balt. Md.

10-NAME OF FATHER

Jos. Alexander

11-BIRTHPLACE OF FATHER, (State or Country)

Va.

12-MAIDEN NAME OF MOTHER

Mary Powell

13-BIRTHPLACE OF MOTHER, (State or Country)

N. Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. Alexander

(Address) 1020 M^c Culloch St.

15-

OCT 9-1922

ROBERT R. MAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Oct. 8, 1922

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Branch Pneumonia

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessey, M. D.

(Coroner.)

Oct 9, 1922 (Address) 2802 Edmond St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68199

CERTIFICATE OF DEATH.

D 68199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Addison ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Otto

(a) RESIDENCE No. 118 Addison

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yr. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Otto

6 DATE OF BIRTH (month, day, and year) Aug 18, 1887

7 AGE 35 Years 1 Months 19 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Ind. (State or country)

10 NAME OF FATHER Jacob Fischknecht

11 BIRTHPLACE OF FATHER (city or town) Switzerland (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Aftalter

13 BIRTHPLACE OF MOTHER (city or town) Switzerland (State or country)

14 Informant Wm. Otto

(Address) 118 Addison

15 OCT 9-1922 ROBERT R. MAUTER, Registrar

Baltimore Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 3, 1922, to Oct 7, 1922

that I last saw him alive on Oct 5, 1922,

and that death occurred, on the date stated above, at 9.50 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY ashenia (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leyman V. Abbott, M. D.

19 (Address) 1832 A. Corbin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

K. B. Wippert 225 Fred St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68200

D 68200

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital, ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Turnbaugh(a) RESIDENCE NO. Unknown

(Usual place of abode)

ST., Unknown WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced, (write the word)
Married

5a If married, widowed, or divorced

HUSBAND of
or) WIFE ofUnknown

6 DATE OF BIRTH (month, day, and year)

1879

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.43----

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workFarmer(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Maryland

10 NAME OF FATHER

John Turnbaugh

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant

Hospital Records

(Address)

Municipal Hospital

15

OCT 9 - 1922ROBERT R. MAUTER

Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 5 1922

17

I HEREBY CERTIFY, That I attended deceased from
Sept. 26, 1922 to October 5, 1922.
that I last saw him alive on October 5, 1922.
and that death occurred, on the date stated above, at 10: P.M. m.

The CAUSE OF DEATH* was as follows:

PneumoniaCONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 10/6/22Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

10/6/22 (Address) Municipal Hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Per. Wm. E. WERNALL

Physicians should state EXACTLY what was the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

27

68201
D 68201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68201

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 543 S. Paca St 22

ST. 129 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 543 S. Paca St

(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced, HUSBAND or (or) WIFE of Kate Cath. Peters

6 DATE OF BIRTH (month, day, and year) March 4, 1857

7 AGE Years 65. Months 7 Days 4 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14

Informant Mrs. Zink

(Address) 4403 1/2 E. Pratt

15

Robert F. Zink

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 1922

17 I HEREBY CERTIFY That I attended deceased from Sept 7, 1922, to Oct 7, 1922.

that I last saw him alive on Oct 7, 1922

and that death occurred, on the date stated above, at 11:55 p.m.

The CAUSE OF DEATH* was as follows:

Chc. Interstitial Nephritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. Atherosclerosis

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. B. Friedlander M. D.

10922 (Address) 672 Cold Ave -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Holy Redeemer Cem.

20 UNDERTAKER

F. C. 9 Trause & Son

19

DATE OF BURIAL

Oct 10 1922

ADDRESS

703 Hanover

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68202

D 68202

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

115 N. Montford Ave

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 115 N Montford Ave., 6

WARD)

2-FULL NAME

Mary Hill Sullivan

(a) RESIDENCE NO.

115 N. Montford Ave., 6

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

13 yrs. 11 mos. 17 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 25-1908

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

13

11

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

Robert H Sullivan

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Alice E Sullivan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore Md

14

Informant
(Address)Father, Robert H Sullivan
115 N Montford Ave

15

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 1, 1922, to Oct 8, 1922,
that I last saw her alive on Oct 8, 1922

and that death occurred, on the date stated above, at 9:50 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Place of death

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Usual clinical

(Signed)

C. E. Keenan, M. D.

19, 1922 (Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Mount Olivet Cem

20 UNDERTAKER

John Smith

DATE OF BURIAL

Oct 11 1922

ADDRESS

2008 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

1922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc., If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Embolus from the mitral insufficiency.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68203

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68203

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *7* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *2331* *Island Ave* St.; yrs. *28* mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH.

unknown 1. (Month) (Day) (Year)

7-AGE.

28 yrs. mos. ds.

IF LESS than 1 day.

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Shoe*

(b) General nature of industry, business, or establishment in which employed (or employer). *Shoe*

9-BIRTHPLACE.

(State or Country). *Balt. Md.*

10-NAME OF FATHER.

Alous Kuchar

11-BIRTHPLACE OF FATHER.

(State or Country). *Bohemia*

12-MAIDEN NAME OF MOTHER.

Marie Polak

13-BIRTHPLACE OF MOTHER.

(State or Country). *Bohemia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Marie Kuchar (Mother)*

(Address) *18 N. Port St.*

15.

Filed *Robert P. Harrison*

1922

1922

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1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Oct 8 192*2* (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest and that said deceased came to *a* death (Inquest, au-

topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Whole surface of body burned. Clothing caught fire when he attempted to go into foreman's of home which was on fire. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Waller*

Oct 9 192*2* (Address) *508 E. North St.*

(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Holy Redeemer

DATE OF BURIAL.

Oct 11 192*2*

20-UNDERTAKER.

Paul C. Smith

ADDRESS

1906 N. North St.

D 68205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68205

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S Stricker ST. 19 WARD)

2-FULL NAME Sophia E. Martin

(a) RESIDENCE. NO. 114 S Stricker ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND (or) WIFE of

James R. Martin

6 DATE OF BIRTH (month, day, and year) Sept 23/1857

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 65 — 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address) James R. Martin 114 S Stricker St

15 Filed Robert P. Harlicks, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1922, to Oct 6, 1922.

that I last saw her alive on Oct 6, 1922.

and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary)

Arterio sclerosis

(duration) yrs. 1 mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Oct 1922 (Address) 1208 N. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Olivet Oct 10 1922

20 UNDERTAKER ADDRESS

Josiah Sykes 1600 N. North St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

19-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68206

D 68206

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Md. Gen Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

Mrs Amy V Lloyd.

ST.

WARD

2-FULL NAME

Mrs Amy V Lloyd

(a) RESIDENCE. No.

3131 W. Calvert

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles H Lloyd

6 DATE OF BIRTH (month, day, and year)

1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

36

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

John Paul Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Germany

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

Henry Lloyd 3131 W. Calvert

15

1922 Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/9 1922

17

I HEREBY CERTIFY, That I attended deceased from

9/25/22 to 10/9/22

that I last saw him alive on 10/9/22, 19

and that death occurred, on the date stated above, at 5:55 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Yes

Date of 9-11-22

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical Symp.

(Signed)

Resonance

M. D.

19 (Address)

Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Riverside Bridge Cemetery

10/11/22

20 UNDERTAKER

George J Smith

ADDRESS

Fayette St

Information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCASION OF DEATH is very important. See instructions on back of certificates.

CT9

D 68207

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68207

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *11 S. Hollington ave* ST. *1* WARD)

2-FULL NAME

(a) RESIDENCE NO.

11 S. Hollington ave ST. *1* WARD
(Usual place of abode) (If non-resident give city or town and State)Length of residence in city or town where death occurred *82* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced., (write the word) *Married*5a If ~~married~~, widowed, or divorced
HUSBAND of
(or) WIFE of *G. H. Bralle*6 DATE OF BIRTH (month, day, and year) *Nov 1839*7 AGE Years *82* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *H. W.*

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *City*
(State or country)10 NAME OF FATHER *Isaac Bowers*11 BIRTHPLACE OF FATHER (city or town) *City*
(State or country)12 MAIDEN NAME OF MOTHER *Constance*13 BIRTHPLACE OF MOTHER (city or town) *City*
(State or country)

14

Informant
(Address) *James H. Bralle*
11 S. Hollington ave

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 7* 19 *22*17 I HEREBY CERTIFY, That I attended deceased from *July 1*, 19 *22*, to *Oct 7*, 19 *22*,
that I last saw her alive on *Oct 6*, 19 *22*,
and that death occurred, on the date stated above, at *11.30 A.M.*

The CAUSE OF DEATH* was as follows:

*Ch. Int. Nephritis**Unknown* (duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)*Dilated Heart* (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

E. P. Mutton M. D.
19 *1911 E. Batts St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL*London Park, (Cem.)*

DATE OF BURIAL

Oct. 10 19 *22*

20 UNDERTAKER

John A. Moran 3000 E. Batts St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68208

CERTIFICATE OF DEATH.

D 68208

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 S. Chester ST.: 1 WARD)

2-FULL NAME

(a) RESIDENCE. No. 343 S. Chester ST.: 1 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31st 19187 AGE Years 3 Months 00 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER Joseph L. Kane11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.12 MAIDEN NAME OF MOTHER Helen Fisher13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.14 Informant Joseph L. Kane (Address) 343 S. Chester St.15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 7 19 2217 I HEREBY CERTIFY, That I attended deceased from Oct 4, 19 22, to Oct 7, 19 22that I last saw him alive on Oct 7, 19 22 and that death occurred, on the date stated above, at 1130 a.m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical signs(Signed) W. J. McAvoy M. D.(Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cemetery Oct 10 19 22

20 UNDERTAKER

John A. Moran 3000 E. Balto St.

Material should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922 Serial Form 10

D 68209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68209

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph's Hosp.*, St. *3* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Walter J. Sosonowski*(Residence in Baltimore: No. *204 S. High* St.; yrs., *5* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*6-DATE OF BIRTH *Sept* 189*0* (Month) (Day) (Year)7-AGE *27* yrs. *+* mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) *Baltimore Dock Co.*9-BIRTHPLACE, (State or Country), *Lithuania*10-NAME OF FATHER, *Vincent J. Sosonowski*11-BIRTHPLACE OF FATHER, (State or Country), *Lithuania*12-MAIDEN NAME OF MOTHER, *Josephine Klem*13-BIRTHPLACE OF MOTHER, (State or Country), *Lithuania*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Josephine K. Sosonowski*(Address) *204 S. High St.*15- *Robert P. BARTLETT;*

1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct* 7, 192*2* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said. *inquiry* find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy - Fall in
convulsions in morning of
Oct 6th, never regained
consciousness (Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) *Port wine cerebral*(Signed) *J. S. H. O. L. H. A. R.* (Duration) yrs. mos. ds.(Address) *508 E. North* (Coroner) M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Holy Redeemer* DATE OF BURIAL, *Oct 11th* 192*2*20-UNDERTAKER, *J. J. L. O. W. S. K. I.* ADDRESS *478 Bond St.*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68210

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *VN Somerset* ST. *5* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *VN Somerset* ST. *5* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *70* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *col.* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Harriet Lindsey*6 DATE OF BIRTH (month, day, and year) *Apr 1904*7 AGE Years Months Days If LESS than 1 day—hrs. or min. *49*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *General*(c) Name of employer *None particularly*9 BIRTHPLACE (city or town) (State or country) *Kingston, N.C.*10 NAME OF FATHER *Wm. Lindsey*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Kingston, N.C.*

14

Informant (Address) *William Lindsey*

15

OCT 10 1922 ROBERT H. MAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *7 Oct. 1922*17 I HEREBY CERTIFY, That I attended deceased from *7 Oct. 1922* to *7 Oct. 1922*that I last saw him alive on *4* 19 *22*and that death occurred, on the date stated above, at *8:25 p.m.*

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegia etc.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *No*Was there an autopsy? *No*What test confirmed diagnosis? *None*(Signed) *Mayfield Boyd*, M. D.Address *4204 Y. Avenue*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Laurel Cemetery

20 UNDERTAKER

Mrs Robert A. Elliott

DATE OF BURIAL

Oct-10 1922

ADDRESS

1725- Ashland

Information should be carefully supplied. AGE should be stated EXACTLY. If possible, state EXACT statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68211

W CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 Biddle ST. 11 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 206 Biddle St. 10 rs. 10 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE

Caucasian

5-SINGLE

MARRIED

WIDOWED

OR DIVORCED

(Write the word.)

6-DATE OF BIRTH,

1867

(Month)

(Day)

(Year)

7-AGE,

55

Yrs.

Mos.

Ds.

If LESS than 1 day,

Hrs. or Min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Gray(Address) 206 Biddle

15-

Filed

OCT 10 1922

ROBERT M. MAUTER,

191

Baltimore Health Department

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 7

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1922, to Oct 7 1922, that I saw him alive on Oct 6 1922, and that death occurred, on the date stated above at 1415.

The CAUSE OF DEATH* was as follows:

Dissected Malignant

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 10 yrs. 10 mos. 10 ds. In the State 10 yrs. 10 mos. 10 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Mt-Aurora CemOct 10 1922

20-UNDERTAKER

ADDRESS

Mrs Robert A. Elliot17261726172617261726172617261726172617261726172617261726172617261726

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Fowles
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68212

CERTIFICATE OF DEATH.

113 ✓ D 68212

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1219 Chatham* ST.: *8* WARD)2-FULL NAME *Wesley Fowles*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. *1219 Chatham* ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *Colored*5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Baby*6 DATE OF BIRTH (month, day, and year) *Sept 22, 1921*

7 AGE

Years *1*

Months

Days *9*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Iron*(b) General nature of industry, business, or establishment in which employed (or employer) *Iron*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country)10 NAME OF FATHER *Gilbert Fowles*11 BIRTHPLACE OF FATHER (city or town) *Va*
(State or country)12 MAIDEN NAME OF MOTHER *Brother Fowles*13 BIRTHPLACE OF MOTHER (city or town) *Va*
(State or country)

14

Informant *Brother Fowles*
(Address) *1219 Chatham*

15

Filed *OCT 10 1922*

19

ROBERT H. RAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 9* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *June 16*, 19*22*, to *Oct 9th*, 19*22*, that I last saw him alive on *Oct 9th*, 19*22*.and that death occurred, on the date stated above, at *7 H.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema & Myocardial Infarction
(duration) yrs. mos. *1* ds.CONTRIBUTORY *Dis-Colitis*
(Secondary)(duration) yrs. mos. *10* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Examine signs*(Signed) *Samuel Miller*, M. D.19 (Address) *1506 N Broadway*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Funeral Home**Oct 10* 19*22*

20 UNDERTAKER

ADDRESS *1725**Mrs Robert A Elliott Ashland*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

D 68213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Morrow Hospital

CITY OF BALTIMORE: (No.

1122 N. Mount

ST. 22 WARD)

2-FULL NAME

Stott, George

(a) RESIDENCE No.

307 S. Sharp

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

207 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single Married, Widowed,
or Divorced, (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

—

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day.....hrs.
or.....min.

60

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Stenographer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Friendly Inn

9 BIRTHPLACE (city or town)
(State or country)

England

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Unknown

14

Informant
(Address)Louis Decker
Friendly Inn

15 OCT 10 1922

ROBERT A. MAUTER,

Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

22

D 68213

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-9 19 22

17 I HEREBY CERTIFY, That I attended deceased from
10-21-19 22 to 10-9-19 22

that I last saw him alive on 10-9-19 22

and that death occurred, on the date stated above, at 12:30 PM

The CAUSE OF DEATH* was as follows:

Bladder Tumor

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Gillis M. D.

, 19 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Frederick Avenue Oct 10 19 22

20 UNDERTAKER

ADDRESS

A. E. Hughes 424 N. Broadway

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart-disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Probably Malignant

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68214

HEALTH DEPARTMENT CITY OF BALTIMORE

D 68214

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1535 E Fayette St. Ward 2)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1535 E Fayette St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 1-COLOR OR RACE, Black 5-Married, Widowed, or Divorced (Write the word.)

6-DATE OF BIRTH, Sept 30 1921 (Month) (Day) (Year)

7-AGE, 1 yrs. 9 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Child (b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Balt Md

10-NAME OF FATHER, Robert Jagan

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Rebecca

13-BIRTHPLACE OF MOTHER, (State or Country), Md

11-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. L. Ginn

(Address) Bess

15-OCT 10 1922 ROBERT R. MAUTER.

Filed 1922 Mortal Perish

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 8 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Baker M. D. (Coroner.)

10-10 1922 (Address) 508 E. Pratt

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

M Zion Oct 10 1922

20-ADDRESS, R. B. Cross 1400 Meloderry

1. Every item of information should be carefully supplied. No statement of occupation is valid unless it is properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D 68215

HEALTH DEPARTMENT—CITY OF BALTIMORE

105 D 68215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 122 So. Patterson Park dr. Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Robert P. Mills

(Residence in Baltimore: No. 122 So. Patterson Park dr. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH

Aug 30th 1850

(Month) (Day) (Year)

7-AGE

72 yrs. 1 mos. 9 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

Water man

9-BIRTHPLACE

(State or Country)

MD

PARENTS.

10-NAME OF FATHER

Wm R. Mills

11-BIRTHPLACE OF FATHER

(State or Country)

MD

12-MAIDEN NAME OF MOTHER

Rebecca Dean

13-BIRTHPLACE OF MOTHER

(State or Country)

MD -

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm R. Mills

(Address)

122 So. Patterson P

15-

Filed

OCT 10 1922

ROBERT R. MAUTER

Notary Public

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Oct 9th 1922

17-I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, Autopsy or Inquiry, thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart Failure

at once

CONTRIBUTORY (Secondary)

Chronic Asthma

(Signed)

John B. Mortimer, M. D.

(Coroner)

Oct 9th 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oxford Md.

Oct 10, 1922

20-UNDERTAKER

ADDRESS

St. Sanders Sons

1710 Fleet St.

D 68216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 68216

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 264/ Penna. Ave. 13

WARD)

2-FULL NAME

William P. Ninton

(Residence in Baltimore: No. 264/ Penna. Ave.

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M.

4-COLOR OR RACE,

White

5-SINGLE

Married
(Write the word.)

6-DATE OF BIRTH

Sept 5 4th 1866
(Month) (Day) (Year)

7-AGE,

56 yrs. 1 mos. 5 ds.
If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Accidental

9-BIRTHPLACE,
(State or Country),

Pa

10-NAME OF FATHER,

J. E. Ninton

11-BIRTHPLACE OF FATHER
(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Mary E. Naskin

13-BIRTHPLACE OF MOTHER
(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edward B. Ninton

(Address)

1765 Montpelier St.

15-

OCT 10 1922

ROBERT H. MAUTER

Filed

101

Baltimore Health Department Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 9, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, or inquiry thereon and from the evidence obtained by said inquest, or inquiry, find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Calculus disease of heart

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Thompson, M. D. (Coroner)

1022 Address. 1232 Rolan

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Alberta, Pa Oct 11, 1922

20-UNDERTAKER ADDRESS

Isiah Syfer 1600 W North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68217

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.:

WARD)

2-FULL NAME

(a) RESIDENCE. No.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a ~~Married~~, widowed, or ~~divorced~~
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

OCT 10 1922

ROBERT R. MAUTER

Registrar

Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Octo. 5th, 1922, to Octo. 10th, 1922
that I last saw her alive on Oct. 9th, 1922

and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Shrike Arteriosclerosis
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? no, Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Marysville Pa Oct 12 22

20 UNDERTAKER

ADDRESS

H S Marshall 3539 Fell Rd

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68218

CERTIFICATE OF DEATH.

100-001 D 68218

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 W. Biddle ST. 11 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 312 W. Biddle ST. 11 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE

Colored

5-SINGLE,

WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

3/8/22, 1922 (Month) (Day) (Year)

7-AGE,

7 yrs. 7 mos. ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),

Bath, Cety.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER,

(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER,

(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed 10-13-22

191

ROBERT N. MAUTER,

Vital Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 8th, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 7th 1922 to Oct. 8th 1922

that I saw him alive on Oct 7th, 1922 and that death occurred, on the date stated above at 3:00 p.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 3 yrs. mos. ds.

(Signed) A. L. B. M. D.

1922 (Address) 312 W. Biddle St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 3 yrs. mos. ds. In the State 3 yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL,

10/10, 1922

FUNERAL

ADDRESS

312 W. Biddle St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68219

D 68219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

JOHNS HOPKINS HOSPITAL

WARD) _____

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harry Cohen

(a) RESIDENCE No. _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. _____

mos. 3

ds. _____

How long in U. S., if of foreign birth?

yrs. _____

mos. _____

ds. _____

WARD _____

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of _____

(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year)

Oct. 22, 1907

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

15

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

Job

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Isidore Cohen

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Fannie Levine

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

OCT 10 1922

ROBERT H. MAUTHE

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 9, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 6, 1922, to Oct. 9, 1922,

that I last saw him alive on Oct. 9, 1922,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor—cerebellar cystic glioma in vermis and cerebellar lobes

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

N.Y.C.

Did an operation precede death?

Yes Date of Oct. 9

Was there an autopsy?

Partial (head)

What test confirmed diagnosis?

X-ray—previous op.

(Signed)

J. K. Reichert M.D.

, 19 (Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

New York City N.Y.

DATE OF BURIAL

10/10 1922

20 UNDERTAKER

Jack Lewis 1439

ADDRESS

3rd Balto

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NAME should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68221

CERTIFICATE OF DEATH.

74-001 D 68221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1329 W. Mount,

ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hagar Brown

(a) RESIDENCE. No.

1329 W. Mount,

ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Samuel Brown

6 DATE OF BIRTH (month, day, and year)

Jan 10, 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

65

8

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Bedridden for 4 months

9 BIRTHPLACE (city or town) (State or country)

West River, Cal. Co. Ind.

10 NAME OF FATHER

Sheldon Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

West River Ind.

12 MAIDEN NAME OF MOTHER

Sarah Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

West River Ind.

14

Informant (Address)

Mary E. Russell 1329 W. Mount

15

File 101922

REGISTRAR
Edward Ruggold

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8 19 22

17

I HEREBY CERTIFY, That I attended deceased from Oct 7 19 22, to Oct 8 19 22, that I last saw her alive on Oct 8 19 22, and that death occurred, on the date stated above, at 9:24 P. M. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Age - Arterio Sclerosis

(duration)

3 months

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William H. Wright M. D.

Oct 9 19 22 (Address) 1207 Prichard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

West River Oct 11 19 22

20 UNDERTAKER

ADDRESS

Edward Ruggold 1463 Carey

N. B.—Every item of information should be carefully supplied. Age should be stated in years, months, and days. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 68222

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68222

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 North Fulton Ave., St. 16 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... James L. Bond M. D.

(Residence in Baltimore: No. 714 N. Fulton Ave., St. 10 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced. (Write the word.)
Male White Single

6-DATE OF BIRTH. April 24, 1841
(Month) (Day) (Year)

7-AGE. 81 yrs. 5 mos. 13 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Physician
(b) General nature of industry, business, or establishment in which employed (or employer). (Retired)

9-BIRTHPLACE. (State or Country). Maryland, Md.

10-NAME OF FATHER. Thos. L. Bond

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary A. Bond

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis E. Bond

(Address) 714 N. Fulton Ave.

15-ROBERT R. KRAUTER, Registrar.

File OCT 10 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 9, 1922
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Signed) J. P. Hennessy M. D.

(Coroner.)

Oct. 14, 1922 (Address) 2503 Edmonson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Union Bridge Co. 12 2

20-UNDERTAKER, ADDRESS

Geo. W. H. & Son 2503 Edmonson Ave.

D 68223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68223

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 ST. 11 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? 50 yrs. 2 mos. 2 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Chesley6 DATE OF BIRTH (month, day, and year) Aug. 7, 18927 AGE Years 30 Months 2 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician(b) General nature of industry, business, or establishment in which employed (or employer) Medicine(c) Name of employer Self9 BIRTHPLACE (city or town) (State or country) Baltimore10 NAME OF FATHER John H. Reguier11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Reger13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Mrs. H. W. Reguier (wife) (Address) 405 Park Ave15 107922 ROBERT H. REAUTE Public Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 192217 I HEREBY CERTIFY, That I attended deceased from Oct. 8, 1922 to Oct. 9, 1922that I last saw him alive on Oct. 9, 1922and that death occurred, on the date stated above, at 11:57 a.m.

The CAUSE OF DEATH* was as follows:

Cellulitis of larynx
neckCONTRIBUTORY Streptococcus Septicemia (duration) 48 hrs yrs. 48 mos. 48 ds.18 Where was disease contracted if not at place of death? 26 hrsDid an operation precede death? Yes Date of Oct. 8, 1922Was there an autopsy? NoWhat test confirmed diagnosis? Findings(Signed) J. H. Reguier M. D.
, 19 (Address) 405 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Lenox Park Burial DATE OF BURIAL Oct 12, 192220 UNDERTAKER STEWART & MOWEN COMPANY ADDRESS 108 W. NORTH AVE.
(WILLIAM F. WOODEN, President)

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68224

CERTIFICATE OF DEATH.

D 68224

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cambridge Apartments

ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Nash Hemmick

(a) RESIDENCE. No. Cambridge Apartments

ST. 12 WARD. (Resident)

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 25 yrs. 10 mos. 27 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Lucien Alan Hemmick

6 DATE OF BIRTH (month, day, and year) Nov-11-1896

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

25

10

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) Norfolk
(State or country) Virginia

10 NAME OF FATHER A. Rowland Nash

11 BIRTHPLACE OF FATHER (city or town) Norfolk
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lula Carroll

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland14 Informant Lucien A. Hemmick, (husband)
(Address) Cambridge Apts. City.

15 Filed

19

ROBERT R. MAUTER
Registrar

OCT 10 1922

Bertel P. P. P.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-8-22 19

17

I HEREBY CERTIFY, That I attended deceased from

9-24, 1922, to 10-8, 1922

that I last saw him alive on 10-8, 1922,

and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

chr. interstitial nephritis.

(duration) 1 yrs. - mos. - ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

John L. Dorsey, M. D.

19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Cemetery (Gowans) OCT-10-22

20 UNDERTAKER

STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D 68225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68225

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Nelson(a) RESIDENCE No. 912 Sterling St

(Usual place of abode)

ST., 10 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Black

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1849

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.

73

--

--

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Laborer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

New York

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant
(Address)

Hospital Records,

Municipal Hospital.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 7 19 22

17

I HEREBY CERTIFY, That I attended deceased from
Sept. 21 19 22 to October 7 19 22.
that I last saw him alive on October 6 19 22.
and that death occurred, on the date stated above, at 5:10 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia of stomach

(duration)

1 yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

4 mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

10/7/19 22

Address

Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

D 68227

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 68227

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1334 A. Carey St. St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1334 A. Carey St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

192 (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an..... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-

topsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUR-
rence of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

THE MORBID

D 68228

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68228

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Goodman

(a) RESIDENCE No.

314 N. Carey St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

October 8 '22

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

1 Day

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

*University Hospital
Baltimore, Md.*

10 NAME OF FATHER

Rollins Goodman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Wilmington Del.

12 MAIDEN NAME OF MOTHER

Elizabeth M. Allen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Wilmington Del.

14

Informant
(Address)*Robert I. ...*

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 9 19 22*

17

I HEREBY CERTIFY, That I attended deceased from

*October 8, 19 22, to October 9, 19 22*that I last saw him alive on *October 9, 19 22*and that death occurred, on the date stated above, at *5:48 P. m.*

The CAUSE OF DEATH* was as follows:

Prematurity 36 weeks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. J. Seeger M. D.

, 19 (Address)

541 N. W. ... Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

C. W. & Rohrer, Inc.

20 UNDERTAKER

DATE OF BURIAL

Oct 10 19 22

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68229

CERTIFICATE OF DEATH.

D 68229

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *622 W. Mulberry* ST.; *19* WARD)2-FULL NAME *George E. Williams*(Residence in Baltimore: No. *(Life) 622 W. Mulberry St.*; *30* yrs., *30* mos., *30* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX *Male*4-COLOR OR RACE, *Caucasian*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widowed*
(Write the word.)6-DATE OF BIRTH, *Feb. 12, 1857*

(Month)

(Day)

(Year)

7-AGE, *65* yrs., *30* mos., *30* ds.If LESS than 1 day, *hrs. or min.*

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Porter*(b) General nature of industry, business, or establishment in which employed (or employer), *186*9-BIRTHPLACE, (State or Country), *Vas*10-NAME OF FATHER, *Stevens Williams*11-BIRTHPLACE OF FATHER (State or Country), *Vas*12-MAIDEN NAME OF MOTHER, *Elyth Bondon*13-BIRTHPLACE OF MOTHER (State or Country), *Vas*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Flora Bailey*(Address), *622 W. Mulberry St.*

15-

Filed *Robert P. HARRISON*, 191 *1932*

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 8, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 12, 1922* to *Oct 8, 1922*, that I saw him alive on *Oct 8, 1922*, and that death occurred, on the date stated above, at *6:30 p.m.*

The CAUSE OF DEATH* was as follows:

Natural Cause
of the Heart
(Duration) *1* yrs., *30* mos., *30* ds.CONTRIBUTORY (Secondary) *Bronchitis*(Signed) *Frank W. Gannon* M. D.
Oct 15, 1922 (Address) *322 N. Green St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *30* yrs., *30* mos., *30* ds. In the State *30* yrs., *30* mos., *30* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Ambrose*DATE OF BURIAL, *Oct 11, 1922*20-UNDERTAKER, *Brown & Kellard*ADDRESS *114 W. 11th St.*

D 68230

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Univ. Hospital ST.: 4 WARD) 782-FULL NAME Hubert J. Gross(a) RESIDENCE. No. Myersville, Md ST.: WARD.

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of 6 DATE OF BIRTH (month, day, and year) — 19057 AGE 17. Years — Months — Days If LESS than 1 day, — hrs. — or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student(b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer 9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Ernest Gross11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Emma Wehr13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md14 Informant Hospital Records (Address) 15 Filed Robert P. Harrington Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 10 19 2217 I HEREBY CERTIFY, That I attended deceased from Oct. 7 19 22 to October 10 19 22that I last saw him alive on Oct. 10 19 22and that death occurred, on the date stated above, at 7:20 P. m.

The CAUSE OF DEATH* was as follows:

Idiopathic Epilepsy

CONTRIBUTORY (Secondary)

(duration) 2 yrs. — mos. — ds.(duration) 2 yrs. — mos. — ds.18 Where was disease contracted if not at place of death? Did an operation precede death? No Date of Was there an autopsy? What test confirmed diagnosis? University Lab findings.(Signed) G. C. Hally M. D.Address Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Myersville, Md

DATE OF BURIAL

10/10/22

20 UNDERTAKER

Chas. F. Evans, Inc.

ADDRESS

118 N. W. Royal

Physicians should state EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OCT 10 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 6823^a

D 68231

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Joseph's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 16 WARD)

2-FULL NAME

Mrs Mary Ranft

(a) RESIDENCE. No.

3428 Edmondson Ave.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

John Ranft

6 DATE OF BIRTH (month, day, and year)

Oct 6 1845

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

77

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Hugh Tracey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary McCallough

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant

(Address)

Joseph E. Ranft
3428 Edmondson Ave.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 12, 1922, to Oct 8, 1922, that I last saw her alive on Oct. 8, 1922, and that death occurred, on the date stated above, at 12:05 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 10 Diabetes Mellitus (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed)

J. J. King

M. D.

19 (Address)

St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park

Oct 11, 1922

Margaret Flynn

1422 Light St.

tion should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1922

Physician should state cause of death in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

D 68232

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D 68232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 E. West)

ST. 23 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Sullivan

(a) RESIDENCE NO. 26 E. West
(Usual place of abode)

ST. 24 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 1868

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

54

✓

✓

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Joel Gutman Co.

9 BIRTHPLACE (city or town)
(State or country)

Balto. Md.

10 NAME OF FATHER

Rudolph Sullivan

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Ann Donolly.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Ireland.

14

Informant
(Address)

Robert Sullivan (Bro.)
26 E. West St.

15

Filed

19

Miss Peritt Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 9 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 8, 1922, to Oct 9, 1922,

that I last saw him alive on Oct 9, 1922,

and that death occurred, on the date stated above, at 2:10 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
and
arteriosclerosis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Ave

20 UNDERTAKER

Maynard J. Thompson

DATE OF BURIAL

Oct 11 1922

ADDRESS

1422 Highland St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68233

CERTIFICATE OF DEATH.

90

D 68233

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2322 Jefferson ST., 7 WARD)

2-FULL NAME John H Sanderling

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2322 Jefferson ST., _____ WARD _____

(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If non-resident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Married Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of Frank J Sanderling (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Dec 22-1885

7 AGE Years 87 Months 10 Days 14 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore City

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER John Sanderling

11 BIRTHPLACE OF FATHER (city or town) Pennsylvania (State or country)

12 MAIDEN NAME OF MOTHER Sarah Rogers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Nathaniel Goldbeck (Address) 2322 Jefferson St

15 Filed _____, 19 _____ Registrar _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 8th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1922, to Oct 8, 1922 that I last saw him alive on Oct 6, 1922 and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart disease
(duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted ✓ if not at place of death?

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical test
(Signed) Dr. Heller M. D.

10/9, 1922 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Green Mount Cemetery DATE OF BURIAL Oct 11 1922

20 UNDERTAKER Dr. C. Miller ADDRESS 2334 Jefferson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68234

D 68234

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 E. Fairmount Ave. ST. 6 WARD)

2. FULL NAME

Elizabeth T. Lewis

(a) RESIDENCE NO.

(Usual place of abode)

2027 E. Fairmount Ave. ST. 6 WARD

Length of residence in city or town where death occurred: Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

J. Leo Lewis

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

J. Leo Lewis 2027 E. Fairmount Ave

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-7 19 22

17 I HEREBY CERTIFY, That I attended deceased from

Sept 15, 19 22 to Oct 7, 19 22

that I last saw her alive on Oct 6, 19 22

and that death occurred, on the date stated above, at 12:45 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fred W. W. M. D.

(Address) 1000 N. ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer (Cem.)

20 UNDERTAKER

J. A. Moran 3000 E. Baltimore St.

DATE OF BURIAL

Oct. 11 1922

ADDRESS

18- Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 68235

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68235

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Med. Gen. Hosp. 15* Ward)

Registered No. C.....

2-FULL NAME... *Cornelius Bremen*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1814 Whitmore St.* St.; yrs. *55* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, *Married* (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, *52* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *house manager* (b) General nature of industry, business, or establishment in which employed (or employer) *Flanagan*

9-BIRTHPLACE, (State or Country), *Balto*

10-NAME OF FATHER, *James Bremen*

11-BIRTHPLACE OF FATHER, (State or Country) *Ireland*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER, (State or Country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Robert Bremen*

(Address) *1814 Whitmore Ave*

15- *Robert P. Carrasco*

1922 *10* Burial Permit No. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 8*, 192*2* (Month) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) yrs. mos. ds. CONTRIBUTORY *accident (fall from stairs)* (Secondary)

(Signed) *J. T. Hennessy* M. D. (Coroner.)

Oct 10, 192*2* (Address) *2802 Leander Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *Lourain Cem* DATE OF BURIAL, *Oct 11*, 192*2*

20-UNDERTAKER, *Martin R. Hayes* ADDRESS *1827 N North*

D 68236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68236

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS H SPITAL ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maude Marshall(a) RESIDENCE NO. Apalachicola Fla. WARD Florida
(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Married
(Married, Widowed, or Divorced, (write the word))5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofMarried6 DATE OF BIRTH (month, day, and year) March 18727 AGE Years Months Days If LESS than 1 day, hrs. or min.
50

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mich.
(State or country)10 NAME OF FATHER Dwight H. Smith11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio12 MAIDEN NAME OF MOTHER Alice Johnson13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mich.14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15

16 REGISTRAR JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10-1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct 3rd, 1922, to Oct 10-, 1922.that I last saw her alive on Oct 10, 1922.and that death occurred, on the date stated above, at 7-0 m.

The CAUSE OF DEATH* was as follows:

Peritonitis, pneumonia(duration) 2 yrs. 8 mos. 8 ds.CONTRIBUTORY (Secondary) Operation - Gallstones(duration) 2 yrs. 8 mos. 8 ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? yes Date of 10/6/22Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) A. H. Blakemore, M. D.19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Apalachicola FlaOct 11 1922

20 UNDERTAKER

ADDRESS

Joseph Adams221 Bway

B-10-21-1500 Bks. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68237

CERTIFICATE OF DEATH.

90 D 68237

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Ramsay ST. 19 WARD)

2-FULL NAME

Valentine Amburg

(a) RESIDENCE. NO. 1508 Ramsay ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

Mary Elizabeth Amburg

6 DATE OF BIRTH (month, day, and year)

July 9-1844

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

78 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired 186

(b) General nature of industry, business, or establishment in which employed (or employer)

Hotel Porter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

do not know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

Mrs Emma Benton 1508 Ramsay St

15

OCT 11 1922

ROBERT R. MAUTER, Registrar

Death Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Oct. 7, 1922, that I last saw him alive on Oct. 7, 1922, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH* was as follows:

myocardial degeneration

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessey, M. D.

19 (Address) 282 E. Enoch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park Bur

DATE OF BURIAL

OCT 11 1922

20 UNDERTAKER

Henry Jenkins & Sons Co

ADDRESS

Orchard

McEldrich

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68239

CERTIFICATE OF DEATH.

D 68239

1-PLACE OF DEATH

CITY OF BALTIMORE, NO. JOHNS HOPKINS HOSPITAL ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lula Bergman

(a) RESIDENCE NO.

852 W. Lombard St. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

(or) WIFE of

Henry Bergman

6 DATE OF BIRTH (month, day, and year)

July 15 - 1874

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.483

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ill.

10 NAME OF FATHER

Jos. Coopersedge

11 BIRTHPLACE OF FATHER (city or town) (State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Mary Sigwalt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ky.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

OCT 17 1922ROBERT R. KAUTERRegistrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 3 1922 to Oct 10 1922that I last saw him alive on Oct 10 1922and that death occurred, on the date stated above, at 12:15 P. M.

The CAUSE OF DEATH* was as follows:

operative death cause not determined - operation for right right pyrocephalus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of 10-9-22Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Karl H. Muth, M. D.19 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western CenOct 12 1922

20 UNDERTAKER

ADDRESS

John J. Cowan Son 901 Hollins St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

JOHNS HOPKINS HOSPITAL ST., 18 WARD)

2-FULL NAME

David Blackwell.

(a) RESIDENCE NO.

808 W. Saratoga St. City

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Marshall & Anna Blackwell.

6 DATE OF BIRTH (month, day, and year)

May 8, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

H

(c) Name of employer

H

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

Marshall Blackwell.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

H

12 MAIDEN NAME OF MOTHER

Anna Jones.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

H

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

OCT 11 1922

ROBERT R. HARRIS

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 7 1922 to Oct 8 1922.

that I last saw him alive on Oct 8 1922.

and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (Not dysentery)

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed)

Horton Casparian, M. D.

19

(Address)

Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

10/11/22

ADDRESS

Robert E. Williams 1106 Oakland Ave

D 68241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68241

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2721 Fenwick Ave

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter L. Mutch

(Residence in Baltimore: No. 2721 Fenwick Ave

St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single
6-DATE OF BIRTH. May 10, 1922 (Month) (Day) (Year)		
7-AGE. 54 yrs., mos. ds.		If LESS than 1 day, hrs. or min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Machinist		

9-BIRTHPLACE.
(State or Country), Pennsylvania

10-NAME OF FATHER, John D. Mutch

11-BIRTHPLACE OF FATHER
(State or Country), Penna

12-MAIDEN NAME OF MOTHER Susan Layman

13-BIRTHPLACE OF MOTHER
(State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Mrs. Mutch

(Address), 2721 Fenwick Ave

15-

Filed

1922

191

ROBERT R. KRAUTER,

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

October

(Month)

9

(Day)

1922

(Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to October 9, 1922, that I saw him alive on Oct 9, 1922, and that death occurred, on the date stated above, at 1035 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) yrs. 3 mos. ds.

CONTRIBUTORY Primary Adeno-Carcinoma

(Secondary) of Gall Bladder (Duration) 1 yrs. 3 mos. ds.

(Signed) Wm. D. Grayly, M. D.

Oct 10, 1922 (Address) 203 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Lebanon Pa

DATE OF BURIAL.

10/12, 1922

20-UNDERTAKER

George J. Ruth

ADDRESS

1735 Harford Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68243

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph Hosp.

ST. 15 WARD 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

234 St. + Montello Boulevard

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Barbara Haber

6 DATE OF BIRTH (month, day, and year)

April 1888

7 AGE 64 Years

Months

Days

If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). (State or country)

Germany

10 NAME OF FATHER

Frederick Haber

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Sue L. Krum

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Louis Haber 607 Fairview Ave

Filed 11/1922 19

N. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 5, 1922, to Oct. 10, 1922.

that I last saw him alive on Oct. 10, 1922.

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pernicious Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. T. Riley, M. D.

, 19 (Address) 1639 N. Broadway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Brooklyn Oct 13 1922

20 UNDERTAKER

ADDRESS

J. M. Cook H. T. Riley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68244

CERTIFICATE OF DEATH.

D 68244

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. *510 S. Rose St.* ST. *1* WARD)

2. FULL NAME

Adolph Reckmann

(a) RESIDENCE NO.

510 S. Rose St

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 3, 1873

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*49**5*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore*

10 NAME OF FATHER

*Unkn*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Germany*

12 MAIDEN NAME OF MOTHER

*Unkn*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Germany*

14

Informant
(Address)*Attilie Reckmann
510 S. Rose St*

15

Filed

*OCT 11 1922**ROBERT R. RAUTER*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 8th 1922

17

I HEREBY CERTIFY, That I attended deceased from
*Sept. 23, 1922, to Oct. 8th 1922,*that I last saw *him* alive on *Oct. 6th 1922*and that death occurred, on the date stated above, at *4 a m.*

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis(duration) *2* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Emaciation*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

At home

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Physical signs

(Signed)

Chas. D. Rees, M. D.10/9/22 (Address) *408 S. Pratt St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Schwarzo

DATE OF BURIAL

Oct 11, 1922

20 UNDERTAKER

Kendall & Apple

ADDRESS

1001 W. 11th St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D 68245

1-PLACE OF DEATH

D 68245

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 544 S Paca

ST. 22 WARD)

2-FULL NAME

None Infant - Bullet

(a) RESIDENCE NO.

544 S Paca

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

10-10-22

7 AGE

Years

Months

Days

If LESS than 1 day, 6 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md

10 NAME OF FATHER

Frank S. Gullett

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balt. Md

12 MAIDEN NAME OF MOTHER

Marta R. Lane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balt. Md

14

Informant (Address)

JOHN

15

Filed

ROBERT R. KRAUTER,

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 19 22

17

I HEREBY CERTIFY, That I attended deceased from

10-10-1922 to 10-10-1922

that I last saw him alive on 10-10-1922

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth 7 1/2 mo

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bay McClary, M. D.

19 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

JOHN HOPKINS HOSPITAL

Oct 10 1922

20 UNDERTAKER

ADDRESS

Commissioner Health

Per. Wm E. WOODALE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EXACTLY. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A STATISTICAL REPORT. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 6824^u

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68246

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 E. Pratt Street ST. 3

WARD)

2-FULL NAME Gittel Bender

(a) RESIDENCE No. 1513 E. Pratt St. ST.

WARD

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)
Length of residence in city or town where death occurred 1¹ yrs. mos. ds. How long in U. S. if of foreign birth? 1² yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zelig Bender

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years 49 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Simon Gloyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hinda Gloyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Zelig Bender (Address) 1513 E. Pratt St.

15 OCT 11 1922 ROBERT H. SHOOTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/11 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 7th 1922 to Oct 11th 1922

that I last saw her alive on Oct 9th 1922

and that death occurred, on the date stated above, at 4⁴ m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) some yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam & Autopsy

(Signed) J. T. Reis, M. D.

19th 1922 (Address) 24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Hessner-Hessing Run

10/11 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 11439 E. Balt

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68247.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D 68247.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

Mercy Hospital ST. *5* WARD)

2-FULL NAME

Anna Burt

(Residence in Baltimore: No.

137 N. Euter Street

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Life
St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

Jan 1, 1912
(Month) (Day) (Year)

7-AGE,

7 yrs. mos. ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

School

9-BIRTHPLACE.
(State or Country),

Baltimore Md

10-NAME OF FATHER,

Isaac Burt

11-BIRTHPLACE OF FATHER
(State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Sarah Faden

13-BIRTHPLACE OF MOTHER
(State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jack Lewis
11439 E B Ave
(Address)

15-

Filed

OCT 11 1922

101

HOWARD R. WEAVER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

10-10-22, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pressure on Vital Center in Medulla
caused by death
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Tracheitis
Pulmonary Edema
(Duration) yrs. mos. ds.

(Signed) *W. H. Burt* M. D.
Oct. 10, 1922 (Coroner.)
11039 Burt (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Westmen Circle DATE OF BURIAL, *10-11-22*

20-UNDERTAKER

Jack Lewis ADDRESS *11439 E B Ave*

✓
ORE
90

D 68248

1-PLACE OF DEATH

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

(a) RESIDENCE NO. 1305 Hull ST. 24 WARD

Length of residence in city or town where death occurred 65 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1922

17 I HEREBY CERTIFY, That I attended deceased from
Oct- 8, 1922, to Oct 10, 1922,
that I last saw him alive on Oct 10, 1922
and that death occurred, on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:

(a) Trade, profession or particular kind of work..... *Housework.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER *Thomas m.c. Intesi*

11 BIRTHPLACE OF FATHER (city or town)
(State or country) *Ireland.*

12 MAIDEN NAME OF MOTHER *Baseline E. Hatter*

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) *Pennsylvania*

14 Informant *Chas. B. Merriam*
(Address) *1325 Hill St*

15
Filed OCT 11 1922
ROBERT
Rudol. Perrellt Registrar

Auto Indignation. 8

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) yrs. 5 mos. - - - ds

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? *yes* Date of *no*

Was there an autopsy?

What test confirmed diagnosis? *None*

(Signed) *Thos. F. Stevens*, M. D.

10/10. 1922 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL	DATE OF BURIAL
Louder Ph. Cemetery	Oct 13 1922

20 UNDERTAKER	ADDRESS
Mrs L. E. Evans & Sons	1428 1/2 Charles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68249

CERTIFICATE OF DEATH.

129

D 68249

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 W. Fayette ST. 18 WARD)

2. FULL NAME

Marion Hartley-Hellyer

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1204 W. FayetteST. 18 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

9 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Dr. F.W. Hartley-Hellyer

6 DATE OF BIRTH (month, day, and year)

Aug 28, 1868

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.54112

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Boston

10 NAME OF FATHER

John Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mass

12 MAIDEN NAME OF MOTHER

Sarah A. Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Boston
Mass

14

Informant
(Address)Dr. F.W. Hartley-Hellyer
1204 W. Fayette St.

15

Filed
19

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1922

17

I HEREBY CERTIFY, That I attended deceased from
Jan 27¹⁴, 1918, to Oct 6, 1922,that I last saw him alive on October 6¹⁴, 1922,and that death occurred, on the date stated above, at 730 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis; chronic Nephritis(duration) 8 yrs. — mos. — ds.CONTRIBUTORY Myocardial Insufficiency
(Secondary)(duration) 6 yrs. — mos. — ds.18 Where was disease contracted Boston
if not at place of death?Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? General Physical & Laboratory examinations(Signed) Thomas B. Dutcher, M. D.At 11, 1922 (Address) 1129 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Woodlawn CemOct 13 1922

UNDERTAKER

ADDRESS

John O. Mitchell1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Intestinal & Bad Heart
drowning*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68250

68250

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2. FULL NAME

Mrs Margaret Flannigan

(a) RESIDENCE NO.

Falls Road, Mt Washington St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

Female White

married

5a If married, widowed, or divorced

(or) WIFE of

Edward Flannigan

6 DATE OF BIRTH (month, day, and year)

Nov. 25, 1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

11

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

William Downey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary Mehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Edw Flannigan 6072 Falls Road

15

OCT 11 1922

ROBERT A. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 9 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 6, 1922, to October 9, 1922.

that I last saw her alive on Oct. 9, 1922.

and that death occurred, on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

Cholecystitis and Cholelithiasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Maryland

Did an operation precede death?

yes Date of Oct. 6, 1922

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) D. J. Persagno, M. D.

19 (Address)

Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Marys Church

10/12/22

20 UNDERTAKER

ADDRESS

J. J. J. J. J.

1318 1/2 St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY STATEMENT SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

Marriglia ✓
HEALTH DEPARTMENT—CITY OF BALTIMORE

5-
161-001
D 68251
REGISTERED NO.

D 68251
1-PLACE OF DEATH 5008 Beaufort Ave
CITY OF BALTIMORE: (No. 307 N Greene ST., WARD)
2-FULL NAME Salvator Marriglia
(a) RESIDENCE No. 307 N Greene ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS
3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day, and year) Oct 10 22
7 AGE Years Months Days 11 LESS than 1 day 8 hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)
10 NAME OF FATHER Andrew J Marriglia
11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)
12 MAIDEN NAME OF MOTHER Fertitta
13 BIRTHPLACE OF MOTHER Italy
(State or country)

14 Informant Andrew J Marriglia
(Address) 307 N Greene St

15 Filed OCT 11 1922 ROBERT R. KAUTER Registrar

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) Oct 11 1922
17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1922, to Oct. 11, 1922, that I last saw him alive on Oct 10, 1922, and that death occurred, on the date stated above, at 6 a. m.
The CAUSE OF DEATH* was as follows:

Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) Edward Marx, M. D.
, 19 (Address) 821 N. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery
20 UNDERTAKER H. M. Rousten

Oct 12 1922
ADDRESS 230 N Greene St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation should be stated. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *South Baltimore Hospital*
CITY OF BALTIMORE: (No. *1828 Mosher* ST. *16* WARD)

2-FULL NAME *Mrs Caroline Hellmig*

(a) RESIDENCE No. *1912 W Mosher* ST. _____ WARD _____
(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *G. Hellmig*

6 DATE OF BIRTH (month, day, and year) *Dec 4-1850*

7 AGE Years *71* Months *10* Days _____ If LESS than 1 day, _____ hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Home work*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country)

10 NAME OF FATHER *Henry Baiele*

11 BIRTHPLACE OF FATHER (city or town) *Germany*
(State or country)

12 MAIDEN NAME OF MOTHER *Rosenberg*

13 BIRTHPLACE OF MOTHER (city or town) *Germany*
(State or country)

14 Informant *Mrs M. Hoffmann*
(Address) *1828 Mosher St*

15 Filed *111922* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 9 1922*

17 I HEREBY CERTIFY, That I attended deceased from *October 4*, 19*22*, to *October 9*, 19*22*, that I last saw her alive on *October 9*, 19*22*, and that death occurred, on the date stated above, at *9 08 P* m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? *No*

Did an operation precede death? *No* Date of _____

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John A. O'Connor*, M. D.

, 19 (Address) *South Baltimore Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn Cemetery

20 UNDERTAKER

W M Routson

DATE OF BURIAL

Oct 12 1922

ADDRESS

223 F W

D 68253

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68253

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2256 Linden Ave* WARD)

2-FULL NAME

Louis Sackerman

(a) RESIDENCE NO.

2256 Linden ST WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Lifetime

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Ida D. Sackerman*

6 DATE OF BIRTH (month, day, and year)

Nov. 15 1883

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*38 10 26*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ladies' Suits &

(b) General nature of industry, business, or establishment in which employed (or employer)

Cloaks.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Balto. Md.*

10 NAME OF FATHER

Samuel M. Sackerman

11 BIRTHPLACE OF FATHER (city or town)

Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Emma Coblenz

13 BIRTHPLACE OF MOTHER (city or town)

Germany.

(State or country)

14

Informant

Mrs. H. H. H. H.

(Address)

2256 Linden Ave.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/11/1922*

17

HEREBY CERTIFY, That I attended deceased from

*Dec. 25, 1921, to Oct 11, 1922.*that I last saw him alive on *Oct. 11, 1922,*and that death occurred, on the date stated above, at *3.15 a. m.*

The CAUSE OF DEATH* was as follows:

acute stenosis.(duration) *21* yrs. mos. ds.CONTRIBUTORY
(Secondary)*organs Pectoris*(duration) *2* yrs. *4* mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Samuel Whitbourne*, M. D., 19 (Address) *1810 Eutaw Place*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Balto. Hebrew Cem.

DATE OF BURIAL

10/13/1922

20 UNDERTAKER

David Sandheim

ADDRESS

1810 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE, D 68254

D 68254

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 Carroll St ST. 21 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed OCT 11 1922, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 1922

17

I HEREBY CERTIFY, That I attended deceased from
Feb 23, 1922, to Oct 9, 1922,
that I last saw h. alive on Oct 9, 1922,
and that death occurred, on the date stated above, at 10.20 P. m.
The CAUSE OF DEATH* was as follows:Cerebral hemorrhage (right side
paralytic)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

10/10, 1922 (Address) 1002 M Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St. Peters Cemetery Oct. 13 1922
James Dignan & Son 1000 S. Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68255

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68255

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

917 S. Paer

ST.;

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Norma Adams

(Residence in Baltimore: No.

917 S. Paer

St.;

yrs.,

6 mos.

2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Fem

4-COLOR OR RACE.

W

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH.

March 18, 1922

(Month)

(Day)

(Year)

7-AGE.

6 yrs. 22 mos. 22 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).

Baltimore

10-NAME OF FATHER.

Martin W. Larp

11-BIRTHPLACE OF FATHER

Baltimore

12-MAIDEN NAME OF MOTHER

Lillian Adams

13-BIRTHPLACE OF MOTHER

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

J. H. Meadows, Jr.
638 Wash Blvd

15-

Robert P. Harrison

Filed

191

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

October 10, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1922, to Oct 10, 1922,

that I saw him alive on Oct 10, 1922,

and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastroenteritis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. 7 ds.

(Signed) J. H. Meadows, Jr., M. D.

10-11-22 (Address) 638 Wash Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 917 S. Paer St.

19-PLACE OF BURIAL OR REMOVAL,

Holy Cross, U.C.C.

DATE OF BURIAL,

Oct. 12, 1922

20-UNDERTAKER

James Dignam & Son

ADDRESS

1000 S. Paer St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68256

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *on Eastern Avenue* St. *12* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Benj. F. Waller -*

(Residence in Baltimore: No. *3200 Abel Ave* St.; yrs. *3* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-Single, Married, Widowed, or Divorced. *Married* (Write the word.)

6-DATE OF BIRTH. *May 29 1873* (Month) (Day) (Year)

7-AGE. *49 yrs. 4 mos. 11 ds.* If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Government Employee* (b) General nature of industry, business, or establishment in which employed (or employer). *Warrent Officer*

9-BIRTHPLACE. (State or Country). *Ga.*

10-NAME OF FATHER. *Don't know*

11-BIRTHPLACE OF FATHER. (State or Country). *l l l*

12-MAIDEN NAME OF MOTHER. *l l*

13-BIRTHPLACE OF MOTHER. (State or Country). *l*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Amir Waller*
(Address) *3200 Abel Ave*

15. Filed *11 1922* 192. *H. A. W.* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Oct 10 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said *inquest* and that said deceased came to *his* death *on the day stated above.* (Copy or inquiry.)

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) *Don't know* ds.

CONTRIBUTORY (Secondary) *Don't know*

(Signed) *H. B. Jones* M. D. (Coroner.)

901 E. 11th St. 1922. (Address) *117 W. Saratoga*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence *Charleston, S.C.*

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. *Washington D.C. Oct 12 1922*

20-UNDERTAKER. ADDRESS. *J. Sander & Sons 1710 Reed St*

Hayes ✓
HEALTH DEPARTMENT—CITY OF BALTIMORE D 68257

D 68257

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

432 Mason St

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 11

WARD)

2-FULL NAME

Lillian Hayes

(a) RESIDENCE. No.

432 Mason St

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

4 mos. 21

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

col

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

5-19-22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

William Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Martha Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Martha Johnson
432 Mason St

15

Filed

276121 130 121922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

Saw his case 10/10 1922

that I last saw him alive on 10/10 1922

and that death occurred, on the date stated above, at 10:15 P.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) James M. Hayes M. D.

19 (Address) 1046 Penn, ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laural Ave

Oct-12 1922

20 UNDERTAKER

ADDRESS

Mrs Robert A. Elliott Oakland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68258

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Hebrew Hosp

REGISTERED NO.

D 68258

CITY OF BALTIMORE: (No.

Monument St & Rutland Ave

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mr Max Brzinskiy

(a) RESIDENCE. No.

120 S. Euter

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

38 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

- 1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

62

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Morris Brzinskiy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Lena Brzinskiy 120 S. Euter St

15

Filed

OCT 12 1922

ROBERT H. HAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 10, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 4, 1922, to Oct 10, 1922,

that I last saw him alive on Oct 10, 1922,

and that death occurred, on the date stated above, at 3.15 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 2 yrs mos. ds.

CONTRIBUTORY (Secondary) retention

Hypertrophy & prolapse of prostate

(duration) 3 weeks ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Miller and Miller, M. D.

10/10/1922 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Ruedale Oct 13 22

DATE OF BURIAL

20 UNDERTAKER

S. Lerman Bro Balt

ADDRESS 1127 E

N. B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68259

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 W - Hoffman ST., 17 WARD)

2. FULL NAME

Maggie Scott

(a) RESIDENCE NO.

532 W - Hoffman ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 28 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Butt Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Centerville

12 MAIDEN NAME OF MOTHER

Lena Gibbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address) 532 W Hoffman St

15

Filed

OCT 12 1922

ROBERT R. KRAUTER
Registrar

Robert R. Krauter
Social Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 - 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 9 - 1922 to Oct 11 - 1922, that I last saw her alive on Oct 9 - 1922, and that death occurred, on the date stated above, at 6,30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. H. Gargill

M. D.

10-11-1922 (Address) 611-7-1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Secret Heart

20 UNDERTAKER

W. H. Gargill

W. H. Gargill
Funeral Directors

DATE OF BURIAL

Oct 13 1922

ADDRESS

1836 W. Pratt Street

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68260

CERTIFICATE OF DEATH.

D 68260

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7308 E. Madison ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Antonie T. Stovak

(a) RESIDENCE. No.

7308 E. Madison ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. — mos. — ds. How long in U. S., if of foreign birth? 24 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rudolph Stovak

6 DATE OF BIRTH (month, day, and year) May 13 1885

7 AGE Years 37 Months 4 Days 27 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bohemia

10 NAME OF FATHER

Anton Tavis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Caroline Stulik

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

14

Informant (Address)

Rudolph Stovak 7308 E. Madison St.

15

Filed

OCT 12 1922

ROBERT R. KAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1922, to Oct 10 1922

that I last saw her alive on Oct 10 1922

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism,

postpartum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Rudolph Stovak, M. D.

, 19 (Address) 821 N. Pratt St. W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cath. Hall Oct 12 1922

20 UNDERTAKER ADDRESS

Frank Evans & Son 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

68261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68261

CERTIFICATE OF DEATH.

113

D 68261

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2311 Foster Ave ST. 1 WARD)

2-FULL NAME

Albert T. Wilson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2311 Foster Ave ST. 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2nd 1912

7 AGE Years 2 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER Wm W. Wilson

11 BIRTHPLACE OF FATHER (city or town) Suffolk Co. Va. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Roland

13 BIRTHPLACE OF MOTHER (city or town) N.Y. (State or country)

14 Informant William W. Wilson (Address) 2311 Foster Ave.

15 Filed OCT 12 1922 ROBERT R. KAUFER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1922 to Oct 11, 1922.

that I last saw him alive on Oct 11, 1922.

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Valente M. D.

19 2 Address 1145 B'nly

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Carmel Cem Oct. 12 1922

20 UNDERTAKER

ADDRESS

Lilly & Ziller

4028. Wolfe

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68262

CERTIFICATE OF DEATH.

161-001

D 68262

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2636 Fennell ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Yme Fennell & Helen Scheiblein(Residence in Baltimore: No. 2636 Fennell St.; _____ yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F 4-COLOR OR RACE, W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
(Write the word.)6-DATE OF BIRTH, Oct 10, 1922
(Month) (Day) (Year)7-AGE, _____ yrs., _____ mos., _____ ds. If LESS than 1 day, 14 hrs. or _____ min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Charles E. Wheeler11-BIRTHPLACE OF FATHER (State or Country), Not known12-MAIDEN NAME OF MOTHER Helen Scheiblein13-BIRTHPLACE OF MOTHER (State or Country), Id.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Zimmerman(Address) 1543 Clifton Ave.

15-

Filed

OCT 12 1922

ROBERT R. MAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 11, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct 10 1922, to Oct 11 1922, that I saw her alive on Oct 1922, and that death occurred, on the date stated above, at 7 a m. The CAUSE OF DEATH* was as follows:This was about a 7 mo. fetus and lived 14 hours
(Duration) _____ yrs., _____ mos., _____ ds.CONTRIBUTORY (Secondary) _____
(Duration) _____ yrs., _____ mos., _____ ds.(Signed) Fred O. Jewett M. D.
Oct 11, 1922 (Address) 2516 Pearson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death _____ yrs., _____ mos., _____ ds. In the State _____ yrs., _____ mos., _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, _____, 192220-UNDERTAKER ADDRESS W. J. ...

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68263

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D 68263

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 231 Dolphin St ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hatter E. Howard

(Residence in Baltimore: No. 231 Dolphin St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE Colored 5-SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH Oct 3 1865
(Month) (Day) (Year)

7-AGE 47 yrs. mos. ds. or min.?
If LESS than 1 day, hrs.

8-OCCUPATION
(a) Trade, profession or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer) John Teacher

9-BIRTHPLACE (State or country) Beth City

10-NAME OF FATHER J. Howard

11-BIRTHPLACE OF FATHER (State or country) Ms.

12-MAIDEN NAME OF MOTHER Mary Perry

13-BIRTHPLACE OF MOTHER (State or country) Ms.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cora Mahan

(Address) 231 Dolphin St

15- OCT 12 1922 ROBERT R. MAUTER, REGISTRAR

Filed 1922

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Oct 9 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 6 1922, to, Oct 9 1922, that I saw h. alive on Oct 8 1922 and that death occurred, on the date stated above, at 091 m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Contributory (SECONDARY) Don't know

(Signed) H. E. Howard M. D.
10-11-22 (Address) 117 N. Main St

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

St. Ambrose Cem Oct 12 1922

20-UNDERTAKER ADDRESS 57

Anna D. Dwyer M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68264

CERTIFICATE OF DEATH.

74-001 D 68264

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. *5212 Alhambra* ST., *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Rachel Isabell Swann

(a) RESIDENCE NO.

5212 Alhambra

4 ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Richard T. Swann

6 DATE OF BIRTH (month, day, and year)

Mar 21 1844

7 AGE

Years

Months

Days

If LESS than

77

10

19

1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John W. Hodge

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Elizabeth Hodge

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant

(Address)

*Mrs Thomas Davis
5212 Alhambra St*

15

Filed

12 1922

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 10* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 9th*, 19 *22*, to *Oct 10*, 19 *22*.

that I last saw her alive on *Oct 10*, 19 *22*.

and that death occurred, on the date stated above, at *9:45 P* m.

The CAUSE OF DEATH* was as follows:

Paralysis (General)

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *at home*

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *No*

What test confirmed diagnosis? *None*

(Signed) *E. H. Duncan*, M. D.

Oct 11, 1922 (Address) *5106 York Road*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

20 UNDERTAKER

Wm Corb

DATE OF BURIAL

Oct 13 1922

ADDRESS

St Paul

Spec. 6-9-19 H. P. Co. - 1600 Bks.

9

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD.

D 68265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-002

D 68265

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Little Walsh ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jane Brown

(a) RESIDENCE. NO.

1813 Little Walsh ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Elijah Brown

6 DATE OF BIRTH (month, day, and year)

33 ?

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Houskeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Self

9 BIRTHPLACE (city or town)
(State or country)

Fairfield Va.

10 NAME OF FATHER

William Waddy

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Hester Easter Oct 10, 192

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Virginia

14

Informant
(Address)

Elijah Brown
1813 Little Walsh

15

Filed

19

ROBERT R. RAUTER

Sanial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 9 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct 7, 19 22, to Oct 9, 19 22.

that I last saw him alive on Oct 9, 19 22.

and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Hepatic

(duration) yrs. mos. 13 ds.

CONTRIBUTORY
(Secondary)

Constipation age,

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis: Physically

(Signed) William H. Wright M. D.

(Address) 1209 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, REMOTION OR REMOVAL

Fairfield
Northumberland Co. Va

DATE OF BURIAL

Oct 12 19 22

20 UNDERTAKER

James H. Dennis

ADDRESS 303

Preston

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68266

CERTIFICATE OF DEATH.

D 68266

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

618 S. Rose

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Leon John Racznick

(a) RESIDENCE. NO.

618 S. Rose

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

6

mos.

24

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 18/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Peter W. Racznick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Anna M. Rakita

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Peter W. Racznick, #618 S. Rose St.

15

Filed

OCT 12 1922

ROBERT K. MAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 12

1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 1, 1922, to Oct. 12, 1922,

that I last saw him alive on Oct. 12, 1922,

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 42 ds.

CONTRIBUTORY (Secondary)

Broncho-Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigiani, M. D.

, 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus, Oct. 13, 1922

20 UNDERTAKER

ADDRESS

W. J. Sadownski

405 S. Ann

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68267

CERTIFICATE OF DEATH.

74-001D 68267

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2220 Eleanor Ave ST. 27 WARD)

2. FULL NAME

Mr. Whitehead Hogendorf

(a) RESIDENCE NO.

Rush Ave Mt Washington ST. 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 8 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Caro Jane Hogendorf

6 DATE OF BIRTH (month, day, and year)

Jan 25 1878

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

44

8

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chemist

(b) General nature of industry, business, or establishment in which employed (or employer)

Soft Drums

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Hogendorf

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Eva Hoch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mrs. Caro Jane Hogendorf, Rush Ave

15

Filed

OCT 12 1922

ROBERT R. MAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 8 1922 to Oct 11 1922

that I last saw him alive on Oct 11 1922

and that death occurred, on the date stated above, at 12:10 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 1/2 ds.

Acute Indigestion

(duration) yrs. mos. 1 1/2 ds.

Chronic Nephritis

18 Where was disease contracted if not at place of death?

Not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. Cox, M.D.

19 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA, Dredge, Cemetery, Oct 13/22

20 UNDERTAKER

ADDRESS

Charles E. Franck, 802 Madison Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

68268 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68268

CERTIFICATE OF DEATH.

68268

D 68268

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *27* ST., *27* WARD)

2. FULL NAME

Edna Sherwood

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 29, 1883*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

39

10

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country) *Maryland*

10 NAME OF FATHER *John B. Sherwood*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore*
(State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Isabelle Miller*

13 BIRTHPLACE OF MOTHER (city or town) *Howard Co.*
(State or country) *Maryland*

14

Informant
(Address)

Mr. Watson Sherwood
Continental Bldg. City.

15

Filed *12-12-22*

Registar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 11* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 4*, 19 *22*, to *Oct 11*, 19 *22*,

that I last saw her alive on *Oct 11*, 19 *22*,

and that death occurred, on the date stated above, at *7:50 A* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Sigmoid Colon

(duration) yrs. *6* mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Oct 10*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *J. H. Wilson* M. D.

, 19 (Address) *Baltimore Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Druid Ridge Cemetery

DATE OF BURIAL

10-13-22

20 UNDERTAKER

H. E. Hughes

434 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

68269

D 68269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68269

D 68269

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wheeler Road ST.: 28 WARD)

2-FULL NAME Katherine Etta Brown

(a) RESIDENCE. NO. Wheeler Road ST., WARD.

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE N 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Sept 24 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) Balt.

10 NAME OF FATHER Lehae L. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fla.

12 MAIDEN NAME OF MOTHER Katherine Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

14 Informant Lehae L. Brown (Address) Wheeler Road

15 Filed OCT 12 1922

ROBERT H. MAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1922, to Oct 12, 1922,

that I last saw her alive on Oct 11, 1922,

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia
Gastro enteritis

(duration) yrs. mos. ds. 3

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds. 3

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S. Hublett M. D.

(Address) 2220 Harrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Family

DATE OF BURIAL

Oct 14 1922

20 UNDERTAKER

ADDRESS

no bill

68270
D 68271

HEALTH DEPARTMENT—CITY OF BALTIMORE

68270

D 68270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO

2-FULL NAME

(a) RESIDENCE. NO

(Usual place of abode)

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (use the word)

6a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

OCT 12 1922 ROBERT R. K. Registrar

Burial Permit Clerk

WARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12th 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1st, 1922, to Oct 12th, 1922,that I last saw her alive on Oct 11th, 1922,and that death occurred, on the date stated above, at 4:15^{PM}, m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert S. Kirk, M. D.

10/12/22 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

2 UNDERTAKER

ADDRESS

Mrs Cook

5027 North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

68271
D 68271

(Martha Sharp.) ✓ N-68271
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 74-001

D 68271

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1119 Rue

ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE No. 1119 Rue

ST. WARD

(If non-resident give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Widow
5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 1872

7 AGE Years Months Days If LESS than 1 day, hrs or min.
50 — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

10 NAME OF FATHER Benj H. Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie Penhagock
(Address) 1119 Rue

15 Filed ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 17 1922 to Oct 10 1922

that I last saw him alive on Oct 10 1922

and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:

Rheumatism and kidney

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) (duration) yrs mos ds.

18 Where was disease contracted 1119 Rue if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Characteristic symptoms

(Signed) Charles H. Fowler M. D.

(Address) 712 S. Sharp Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

MOVAT Mt. Auburn Oct 13 1922

20 UNDERTAKER ADDRESS 142

John H. Toadine W. Hill

D 68272 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68272

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1703 Beekman ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Infant of Mr & Mrs C.E. Broge

(a) RESIDENCE. NO.

1703 Beekman ST., 24 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 11/1922

7 AGE

Years

Months

Days

If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

C.E. Broge

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Sturtevant, Wis.

12 MAIDEN NAME OF MOTHER

Mary D. Freeman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Mrs Broge 1703 Beekman St.

15

Filed

19

ROBERT R. KAUFER Registrar

OCT 13 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 4, 1922, to Oct 12, 1922

that I last saw him alive on Oct 11, 1922.

and that death occurred, on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? smallpox

(Signed) H.P. Campbell, M.D.

19 (Address) 1644 St. Louis

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

New Catholic Home Oct 13 1922

20 UNDERTAKER

ADDRESS

Mrs E. E. and Son 1425 Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D 68273 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

68273

D 68273

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 139 W. Hill ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Richardson

(a) RESIDENCE NO. 139 W. Hill ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Bertha E. Richardson (or WIFE of) Mrs. Bertha E. Richardson

6 DATE OF BIRTH (month, day, and year) Mar. 2nd 1882

7 AGE Years 40 Months 7 Days 8 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) Contracting & Building (c) Name of employer (?)

9 BIRTHPLACE (city or town) M. B. (State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Isabelle Boone

13 BIRTHPLACE OF MOTHER (city or town) M. B. (State or country)

14 Informant Bertha E. Richardson (Address) 1122 Haverhill St.

15 Filed 13-1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 7th 1922 to Oct 10th 1922.

that I last saw him alive on Oct 10th 1922.

and that death occurred, on the date stated above, at 3⁰⁰ m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Colon) (duration) about 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. H. Curwile M. D.

1012 1922 (Address) 1400 Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

1012 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68274 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Sharp ST. 13 WARD)

2. FULL NAME

Edward Nathaniel Varner

(a) RESIDENCE NO.

1143 Sharp

ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs. 1 mos. 10 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE C. 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1920

7 AGE Years 2 Months 1 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Fairfield, Balto. Md.

10 NAME OF FATHER

Edward Varner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mayville Tenn.

12 MAIDEN NAME OF MOTHER

Lola Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Salisbury N.C.

PARENTS

14 Informant (Address)

Edward Varner
1143 Sharp St.

15

Filed OCT 13 1922

ROBERT R. KAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1922 to Oct 12, 1922, that I last saw him alive on Oct. 12, 1922, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 10 hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo B. Davis M. D.

(Address) 211 Church St., Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Furnace Branch et

20 UNDERTAKER

L. L. Brown & Son

DATE OF BURIAL

Oct 14 1922

ADDRESS

10 W. Mount

Spec. - 1-10-21 - M&T - 1500 Bks.

68278

21

D 68275

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 68275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2543 McKim ST. 20 WARD)

2-FULL NAME Elizabeth Eberman

(a) RESIDENCE NO. 2543 McKim ST. WARD (If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female. 4 COLOR OR RACE white. 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND or (or) WIFE of Adam Eberman

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE 64 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Housework (b) General nature of industry, business, or establishment in which employed (or employer) at home (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

10 NAME OF FATHER Henry West

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Kreutz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John F. West (Address) 2543 McKim St.

15 Filed 1922 Registrar Herbert R. Hauser

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 10 1922

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1922, to Oct 10, 1922, that I last saw her alive on Oct 10, 1922, and that death occurred, on the date stated above, at 8.15 p. m. The CAUSE OF DEATH* was as follows: facial erysipelas, nephritis, cardiac insufficiency (Mitral & aortic valves).

(duration) yrs. 4 mos. 15 ds.

CONTRIBUTORY (Secondary) Pulmonary edema. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1207 Carroll St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. 19 M. D. 1922 (Address) 1002 St. Carroll

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Western Cemetery DATE OF BURIAL Oct 13 1922

20 UNDERTAKER Geo Leimbach & Son ADDRESS 647 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68276

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 7th Monell Park ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME August Strinsky

(a) RESIDENCE NO. 1011 7th Monell Park ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Oct 20 1903

7 AGE Years Months Days At LESS than 1 day, hrs. or min. 18 11 22

8 OCCUPATION OF DECEASED Butcher

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Schluterer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER August Strinsky

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Lubow

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country)

14 Informant August Strinsky

(Address) Monell Park

15 1922

16 1922

17 1922

18 1922

ROBERT R. KRAUTER

Barial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1922

17 I HEREBY CERTIFY, That I attended deceased from

May 23, 1922, to Oct 10, 1922,

that I last saw him alive on Oct 10, 1922,

and that death occurred, on the date stated above, at 1145 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriologic

(Signed) Thos B Hall, M. D.

, 19 (Address) Baltimore

*State the Disease Causing Death, or in death from Violent Causes, state (1) Manner and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Oct 16 1922

20 UNDERTAKER

MRS. M. S. FINE

FUNERAL DIRECTOR

1830 W. PRATT STREET

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68277.

CERTIFICATE OF DEATH.

74-001 D 68277.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Beechwood Ave ST. 12 WARD)

2-FULL NAME

Frank. H. Beierlein

(a) RESIDENCE NO. 7 Beechwood Ave. ST. 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 5 mos. 26 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Mary. C. Beierlein

6 DATE OF BIRTH (month, day, and year)

Apr. 25 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

66

5

26

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Finisher on

(b) General nature of industry, business, or establishment in which employed (or employer)

Polished Caskets

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Frederick Beierlein

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant (Address)

Mr. Mary C. Beierlein 7 Beechwood Ave

15

Filed

Oct 13 1922

ROBERT R. KAUFER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 10, 1922, to Oct 11, 1922

that I last saw him alive on Oct 11, 1922

and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Schuman, M. D.

19 (Address) 4702 Harper Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Baltimore Cemetery

Oct 14 1922

20 UNDERTAKER

ADDRESS

Henry Hock Lee

1301 E. Egan St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68278

CERTIFICATE OF DEATH.

D 68278

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 N. Central Ave. ST. 10 WARD)

2-FULL NAME

(Residence in Baltimore: No. 825 N. Central Ave. St.; 22 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE,

MARRIED, Widowed, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH.

August 23, 1890
(Month) (Day) (Year)

7-AGE.

32 yrs., 1 mos., 19 ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country), Harford Co. Md.

10-NAME OF FATHER.

John C. Zimmerman

11-BIRTHPLACE OF FATHER.

(State or Country), Germany

12-MAIDEN NAME OF MOTHER.

Angeline Bennington

13-BIRTHPLACE OF MOTHER.

(State or Country), Pa.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) 825 N. Central Ave.

15-

Filed

101

Register.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

October 12, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 5, 1912, to Oct 12, 1912,

that I saw him alive on Oct 11, 1912,

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. 1 mos. ds.

(Signed)

10/12/22, 1912 (Address) 1301 E. Eager St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Baltimore Cemetery

DATE OF BURIAL.

Oct 16, 1912

20-UNDERTAKER

Henry Beckman

ADDRESS

1301 E. Eager St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68279

CERTIFICATE OF DEATH

100-001

REGISTERED No. C.

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 Roland Ter. Roland Ter. WARD)

2-FULL NAME

Catherine Hazelton

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 210 Roland Ter. St.; 6 yrs. 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX F 4-COLOR OR RACE White 5-SINGLE Single
MARRIED
WIDOWED
OR DIVORCED
(Write the word)

6-DATE OF BIRTH

unknown place, about 1899
(Month) (Day) (Year)

7-AGE

75 about If LESS than
1 day, hrs.
yrs. 6 mos. 6 ds. or min.?

8-OCCUPATION

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

maid

9-BIRTHPLACE
(State or country)

Md

10-NAME OF FATHER

unknown

11-BIRTHPLACE OF FATHER
(State or country)

Md

12-MAIDEN NAME OF MOTHER

Deborah - unknown

13-BIRTHPLACE OF MOTHER
(State or country)

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mr. J. H. Lewis

(Address)

210 Roland Ter.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

Oct 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 10/9, 1922, to 10/12, 1922, that I saw him alive on 10/11, 1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Brain - Pneumonia

(Duration) 3 mos. 3 ds.
Contributory (SECONDARY) Myocarditis known
See for 3 years

(Signed) Harry F. Cassidy M. D.
1912 1922 [Address] Roland Ter.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [For Hospitals, Institutions, Transients, or Recent Residents]

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

David City

DATE OF BURIAL

10-14, 1922

20-UNDERTAKER

George H. Holland

ADDRESS

1631 Knickerbocker Hill

18- OCT 13 1922

ROBERT H. KAUFER

191

191

BURIAL PERMITS REGISTRAR

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1900 Bks.

D 68280

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68280

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Presstman

ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mima Streams

(a) RESIDENCE. No. 1622 Presstman

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Wm. H. Streams

6 DATE OF BIRTH (month, day, and year) 6-1862

7 AGE 60 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prince George's Co. Md.

10 NAME OF FATHER Moses Hebron

11 BIRTHPLACE OF FATHER (city or town) Prince George's Co., Md.

12 MAIDEN NAME OF MOTHER Rosie Harris

13 BIRTHPLACE OF MOTHER (city or town) Prince George's Co., Md.

14 Informant (Address) Walter Streams, Son 1622 Presstman St.

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11 1922

17 I HEREBY CERTIFY, That I attended deceased from 10-3-1922, to 10-10-1922,

that I last saw her alive on 10-10-1922,

and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page M. D.

19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL

St Peter Cmn

DATE OF BURIAL

Oct 14 1922

20 UNDERTAKER

Joseph A. Farrell

ADDRESS

1720 N. Mount St.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68281

David Tucker
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68281

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7th Janfield ST. 25 WARD)

2-FULL NAME

David Tucker
7th Janfield ST.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE Years 2 Months 1 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shopper
(b) General nature of industry, business, or establishment in which employed (or employer) Chamber 086
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER John Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) John Tucker 7th Janfield St. 25

15 Filed 131922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/10 - 1922

17 I HEREBY CERTIFY, That I attended deceased from 10/4 - 1922, to 10/10 - 1922, that I last saw him alive on 10/10 - 1922

and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Hypertension (duration) yrs. 4 mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. H. Hays M. D.

19 (Address) 1340 1/2 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER J. C. Gross 1400 McElroy

UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 68282

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2010 Penna. Ave. ST. 15 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2010 Penna. Ave. St. 1 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Dec. 16, 1868 (Month) (Day) (Year)

7-AGE,

54 yrs. 9 mos. 21 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Janitor Office Bldg.

9-BIRTHPLACE, (State or Country),

Kentucky

10-NAME OF FATHER,

Anthony Taylor

11-BIRTHPLACE OF FATHER (State or Country),

Kentucky

12-MAIDEN NAME OF MOTHER

Mary Taylor

13-BIRTHPLACE OF MOTHER (State or Country),

Kentucky

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Annie Taylor (Wife) 2010 Penna. Ave.

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 11, 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to Oct 11, 1922, that I saw him alive on Oct 11, 1922, and that death occurred, on the date stated above, at 7:40 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) C. Williams, M. D. Oct 12, 1922 (Address) 1928 Penna. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cemetery

DATE OF BURIAL,

Oct. 13, 1922

20-UNDERTAKER

Jno. M. Johnson

ADDRESS

1234 E. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) JOHNS HOPKINS HOSPITAL 17 WARD)

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 28, 19 22, to Oct 12, 19 22,

that I last saw him alive on Oct 12, 19 22,

and that death occurred, on the date stated above, at 12:10 A.M.

The CAUSE OF DEATH* was as follows:

Meningitis, secondary to
Pyogenic gastric ulcer with
abscess formation in cerebello-
cavity (duration) yrs. mos. 4/12/22CONTRIBUTORY Abscess, pyogenic gastric
(Secondary) ulcer (duration) yrs. mos. 2/ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/20/22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

1612, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 13 1922

RESERVED FOR BINDING
THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 100 Rhs.

D 68284

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 68284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1634 Pressman

ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Westley Hall

(a) RESIDENCE NO. 1634 Pressman
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Hall

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Wm. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) 16 24 Westman St

15 Filed 13 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 11, 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept. 27, 1922, to Oct. 11, 1922,

that I last saw him alive on Oct. 11, 1922,

and that death occurred, on the date stated above, at 10-10 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach (Pyloric)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER James H. Davis

Oct. 14, 1922

ADDRESS 303

68285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68285

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 314 Gunpowder St., 1 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 314 9 sumner st St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEP-72

4-COLOR OR RACE.

5-Single,
Married,
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH.

7-AGIL.

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country)

10-NAME OF
FATHER.

II-BIRTHPLACE
OF FATHER,
(State or Country).

12-MAIDEN NAME
OF MOTHER.

13-BIRTHPLACE
OF MOTHER,
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant:

(Address)

15-

1121

102

ROBERT K. BRAUER

.....Permit Clerk.....

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held on 12/1/68
(Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said..... (Inquest, au-
opsy or inquiry)..... find that said deceased came to..... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

192 (Address)

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68286

CERTIFICATE OF DEATH.

D 68286

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 Lewis

ST. 5

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas Lewis

(Residence in Baltimore: No. 409 Lewis

St. 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

widowed

6-DATE OF BIRTH,

Unknown, 1863.
(Month) (Day) (Year)

7-AGE,

approx 59 yrs., mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Steward

9-BIRTHPLACE, (State or Country),

Va

PARENTS.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

unknown

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Gleaves

(Address) 409 Lewis St

15-

Filed OCT 13 1922

191

ROBERT H. RAUTER

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 12, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 29 1922, to Oct 12 1922,

that I saw him alive on Oct 10 1922,

and that death occurred, on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) ... yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. mos. ds.

(Signed) R. J. Young M. D.

10/12, 1922 (Address) 129 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. mos. ds. In the State ... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Laural Cemetery

DATE OF BURIAL,

Oct 13, 1922

20-UNDERTAKER

Mrs. Robert A. Elliott

ADDRESS

1725 Reeland St

THIS IS A PERMANENT RECORD
 PHYSICIANS should state
 AGE should be stated EXACTLY. Exact statement of OCCUPATION is very
 important. See instructions on back of certificate.

D 68287

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68287

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST.; _____ WARD)

REGISTERED NO. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME _____

(Residence in Baltimore: No. _____ St.; _____ yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) _____

(Address) _____

15-

Filed _____

191 _____

Registrar _____

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) _____ (Day) _____ (Year) _____

17- I HEREBY CERTIFY, That I attended deceased from _____ 1903, to _____ 1922, that I saw him alive on _____ 1922, and that death occurred, on the date stated above, at 4:30 p.m. The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) _____ M. D.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death _____ yrs. _____ mos. _____ ds. In the _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

THIS IS A PERMANENT RECORD. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68288

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 S. Fremont Ave ST.: 18 WARD)

2-FULL NAME

(Residence in Baltimore: No. 14 S. Fremont Ave St.: 35 yrs., 1 mos., 2 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (If not the word.)

Married

6-DATE OF BIRTH,

Unknown, 1

(Month)

(Day)

(Year)

7-AGE,

56 yrs., 1 mos., 2 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Harry Glasman

(Address)

743 W. Fayette St.

15-

Filed OCT 13 1922

191

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct

13, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to Oct 12 1922,

that I saw him alive on Oct 12 1922,

and that death occurred, on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY Cardiac Dilatation

(Secondary) (Duration) yrs. mos. ds.

(Signed) Harry Glasman M. D.

Oct 13, 1922 (Address) 743 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Baltimore

20-UNDERTAKER

E. Patterson

DATE OF BURIAL,

Oct 13, 1922

ADDRESS

1127 E. Baltimore St.

THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be stated EXACTLY. PHYSICIANS of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68290

CERTIFICATE OF DEATH.

113

D 68290

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 Pitcher

ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ozzy Dilworth

(a) RESIDENCE. NO.

627 Pitcher

ST.: 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

6/7/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Junius Dilworth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. C.

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11 1922

17

I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19,

that I last saw him alive on, 19,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
"Summer Complaint"

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. M. D.

19 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as Day laborer, Farm laborer, Laborer—Coal mine, etc. Women at home, who are engaged in the duties of the household only (not paid Housekeepers who receive a definite salary), may be entered as Housewife, Housework, or At home, and children, not gainfully employed, as At school or At home. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as Servant, Cook, Housemaid, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: Farmer (retired, 6 yrs.). For persons who have no occupation whatever, write None.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: Cerebrospinal fever (the only definite synonym is "Epidemic cerebrospinal meningitis"); Diphtheria (avoid use of "Croup"); Typhoid fever (never report "Typhoid pneumonia"); Lobar pneumonia; Bronchopneumonia ("Pneumonia," unqualified, is indefinite); Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles;

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Patient not seen until
after death
no signs of other than
natural death.
Respectfully M. D.
Health officer 14 ward*

Spec. - 1-10-21-M&T-1500 Bk. 68291

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

68291

Bruck 968291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: Home for Invalids 19 ST. WARD

2-FULL NAME Ella A. Bruck

(a) RESIDENCE NO. 1310 N. Mulberry ST. WARD

(Usual place of residence)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 3-1853

7 AGE 69 Years 3 Months 9 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Henry M. Bruck

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Anna M. Lindenbaum

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Charles W. Bruck (Address) 1310 N. Mulberry St.

15 Filed OCT 13 1922 ROBERT H. FRADLER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1922

17 I HEREBY CERTIFY, That I attended deceased from May 1922, to Oct 12 1922, that I last saw her alive on Oct 12 1922, and the death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows: Septicemia from extensive infected bed-sores—

CONTRIBUTORY (Secondary) Chronic Nephritis—over 7 yrs. 8 mos. ds. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? (Signed) W. S. Mayo M. D. (Address) Baltimore, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT Baltimore Cemetery

DATE OF BURIAL Oct 14 1922

20 UNDERTAKER Ser. Weber & Son 2503 Edmond St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST., *120* WARD)2-FULL NAME *Mrs. Elina Meyer*(a) RESIDENCE NO. *Thimfield Md.* ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.*4 COLOR OR RACE *W.*5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of *G. G. Meyer*6 DATE OF BIRTH (month, day, and year) *1874-2-20*

7 AGE

Years *48*Months *7*Days *22*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *037*(b) General nature of industry, business, or establishment in which employed (or employer) *Housewife*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md.*10 NAME OF FATHER *Robert Meyer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Mrs. R. G. Meyer Thimfield Md.*

15

Filed

19

Burial Permit

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10-12-22*

17

I HEREBY CERTIFY, That I attended deceased from *10-11-22*, 19 *22*, to *10-12-22*, 19 *22*.that I last saw him alive on *10-12-22*, 19 *22*.and that death occurred, on the date stated above, at *6.25 P.m.*

The CAUSE OF DEATH* was as follows:

Acute Yellow Atrophy of Liver (?)(duration) yrs. mos. *7* ds.CONTRIBUTORY (Secondary) *Pulmonary Edema*(duration) yrs. mos. *12* ds.18 Where was disease contracted if not at place of death? *No*Did an operation precede death? *No* Date of _____Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *H. Harper*, M. D., 19 (Address) *St. Agnes Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *St. Agnes Hosp.*

DATE OF BURIAL

20 UNDERTAKER *St. Agnes Hosp.*

ADDRESS

*G.M. Maltz**Thimfield Md.*

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Exact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

1068294 HEALTH DEPARTMENT—CITY OF BALTIMORE 1068294

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3503 E Bank ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Henry Zwick

(a) RESIDENCE NO.

3503 E BankST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

about 60

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofBerta M. Zwick

6 DATE OF BIRTH (month, day, and year)

Dec 20 1858

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.631316

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workBaker(b) General nature of industry,
business, or establishment in
which employed (or employer)Pittsburg

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Christian Zwick

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Gertude Zimmerman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)Mrs. Berta Zwick
3503 E Bank St

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 12, 1922, to Oct 12, 1922.that I last saw him alive on Oct 12, 1922.and that death occurred, on the date stated above, at 2:24 p.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

Frank A. Glantz, M. D.

(Address)

3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALOak Lawn

DATE OF BURIAL

Oct 15 1922

ADDRESS

20 UNDERTAKER

X. Heemann1317 Broadway

N. B.—Every item of information should be carefully checked, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.68295 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital..... St., 6..... Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... J. Thomas Gorsuch.....

(Residence in Baltimore: No. 121 N. Kenwood Ave...... St.; yrs.,..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, September 17, 1862..... 1..... (Month) (Day) (Year)

7-AGE, 59 yrs., -- mos., 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Weigher, American. (b) General nature of industry, business, or establishment in which employed (or employer), Sugar Refinery.

9-BIRTHPLACE, (State or Country), Maryland.

10-NAME OF FATHER, James Gorsuch.

11-BIRTHPLACE OF FATHER, (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Sarah Plumer.

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth M. Gorsuch (wife)

(Address) 121 N. Kenwood Ave.

15- Robert P. Harrison

Filed 131922 1922 Public Health Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 11th 1922....., 192..... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of right leg & thigh, foot
& left arm. shock.
Accidentally caught in a barrel
conveyer. (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary).....

(Signature) Otto M. Reinhardt..... ds. (Coroner) Oct. 12, 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?..... American Sugar Refinery, Oct. 9, 1922.

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, Oct 14..... 1922

20-UNDERTAKER, Ginkler & Ginkler ADDRESS 1739 E. Esqu St.

Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

DL. 68296

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL. 68296

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 E. University Parkway ST. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Milholland

(a) RESIDENCE NO. 219 E. University Parkway ST. 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 3 mos. 22 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Arthur V. Milholland

6 DATE OF BIRTH (month, day, and year) June 19, 1846

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 76 3 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Patrick Reilly

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Mullin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant F. X. Milholland (Address) 219 E. University Parkway

15 Filed 13 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-11 1922

17 I HEREBY CERTIFY, That I attended deceased from 10-5-1922 to 10-11-1922.

that I last saw her alive on 10-11-1922.

and that death occurred, on the date stated above, at 12:40 P. M.

The CAUSE OF DEATH* was as follows:

BRONCHOPNEUMONIA

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Dorsey, M. D.

, 19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cemetery

DATE OF BURIAL

10/ 19 22

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

D. 68297

HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68297

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 327 W. Belvidere St. 28th WARD

2-FULL NAME

Edward M. Kelly, Junior

(a) RESIDENCE

No. 327 W. Belvidere St. 28th WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. 2 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

8/14/21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

Edw. M. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md

12 MAIDEN NAME OF MOTHER

Minnie B. Balt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md

14

Informant (Address)

Edw. M. Kelly 327 W. Belvidere St.

15

Filed

Robert P. Harrison, Registrar

Registrar

16 DATE OF DEATH (month, day, and year) 10/13 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1922, to Oct. 13, 1922,

that I last saw him alive on Oct. 12, 1922, and that death occurred, on the date stated above, at 8. A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? objective subjective (Signed) Dr. M. D. Grant (Address) 4766 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Woodlawn Cemetery Oct 14 1922

20 UNDERTAKER

Josiah Syper 1600 W. North

Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

13

922

Baptist Permit Clerk

22.68298

HEALTH DEPARTMENT—CITY OF BALTIMORE

22.68298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

6-DATE OF BIRTH

7-AGE

IF LESS than 1 day

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE

(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15.

16.

Robert P. Harrison,

Barial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by said

and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH was as follows:

Heart Failure or asphyxiation
(Was singular or double)
Shut Cor. Ar. route home

CONTRIBUTORY (Secondary)

(Signed)

10-13 1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

*Remarks on the death of a child at age 7
 Brungt into Hospital (Hansmann) of
 cancer-developed symptoms of 1822
 after 10 days at home*

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

H. 68300

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST.: *4* WARD)

2-FULL NAME

Selma Koestner

(a) RESIDENCE. NO.

Sanders Range ST.: *4* WARD. *Glenburnie, Md.*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1*

mos.

ds.

How long in U. S., if of foreign birth?

yrs. *7*

mos.

ds.

REGISTERED NO. *10.68300*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Alfred Koestner*

6 DATE OF BIRTH (month, day, and year)

6-7-1875

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*47*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

August Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Jekla Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant
(Address)*Alfred Koestner
Sanders Range*

15

Filed

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 11 1922*

17

I HEREBY CERTIFY, That I attended deceased from *October 10, 1922*, to *October 11, 1922*, that I last saw her alive on *October 11th*, 1922, and that death occurred, on the date stated above, at *5²⁵ P.*

The CAUSE OF DEATH* was as follows:

Laceration of thumb of left hand(duration) yrs. *12* mos. *3* ds.CONTRIBUTORY
(Secondary)*Acute Tetanus*(duration) yrs. *3* mos. *3* ds.18 Where was disease contracted if not at place of death? *Glenburnie, Md.*Did an operation precede death? *NO* Date of *—*Was there an autopsy? *NO*What test confirmed diagnosis? *Clinical findings*(Signed) *Anthony V. Buckner*, M. D., 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cedar Hill

20 UNDERTAKER

Wm Cook

DATE OF BURIAL

10/14 1922

ADDRESS

5028 North

Information should be carefully supplied. Exact statement of OCCASION CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OCT 13 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 19 WARD)

2-FULL NAME Maggie Stranz

(a) RESIDENCE NO. 610 S. Fulton Ave. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1857
7 AGE Years Months Days If LESS than 1 day, hrs or min. 65 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Hair Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Adan Stranz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records, Municipal Hospital.
(Address)

15 Filed Robert P. HARRISON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept. 6, 19 22, to October 12, 19 22, that I last saw her alive on October 11, 19 22, and that death occurred, on the date stated above, at 1:30 A.M. The CAUSE OF DEATH* was as follows:

Chronic myocarditis

CONTRIBUTORY (Secondary) (duration) 20 yrs. mos. ds. Pneumonia umbilicus (duration) 2 yrs. ? mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Clyde M. Hall, M. D.

10/12/22 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore

20 UNDERTAKER

Wm Corle

DATE OF BURIAL

Oct 14 1922

ADDRESS

502 E. North

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D. 68302

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. _____)

ST., 12

WARD)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Weaver(a) RESIDENCE NO. 2410 Sisson

(Usual place of abode)

ST., _____

WARD _____

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

(or) WIFE of

Eva Weaver6 DATE OF BIRTH (month, day, and year) Sept 7th 1905

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

17 1 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

Fredrick H. Weitzell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Abie Ash

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 11 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 9th 1922 to Oct 11th 1922.that I last saw him alive on Oct 11th 1922.and that death occurred, on the date stated above, at 10³⁰ A.m.

The CAUSE OF DEATH* was as follows:

Eclampsia36 4^{1/2}

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. W. Gray

M. D.

19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MORAL

20 UNDERTAKER

ADDRESS

St. Marys Hospital
Chenoweth, Lorch, & Co.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

of Pregnancy

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68303

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 333.9th 30th ST., 12 WARD)

2. FULL NAME

(a) RESIDENCE NO. 333.9th 30th

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

ST., WARD (If non-resident give city or town and State) yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male, White married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

Emily J. Keith

6 DATE OF BIRTH (month, day, and year)

July 8/1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

3.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Emily J. Keith 333.9th 30th St.

15

Filed

ROBERT P. HARRIS, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1922

17 HEREBY CERTIFY, That I attended deceased from

Aug 20, 1922 to Oct 12, 1922

that I last saw him alive on Oct 11, 1922

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma in submaxillary region

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? None needed

What test confirmed diagnosis? Inspection

(Signed) R. B. Norman M. D.

10.13.1922 (Address) 3543 Chestnut St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Woodlawn Cem.

Oct 14, 1922

Gunnor & Son

3617

Chestnut St.

Exact statement of OCCUPATION should be carefully supplied. AGE should be supplied in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

14 1922

Burial Permit Clerk.

D. 68304 HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68304

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216, S. Bruce ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE, NO. 216 S Bruce ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

7

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

none

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

6

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

August Laker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Dora Schaffert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

August Laker 216 S Bruce St

15

Filed

HARRISON

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 13, 1922, to

that I last saw him alive on Oct 13, 1922.

and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Gastroenteritis (spasms)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical

(Signed) H. Kelly Hemming, M.D.

10/3, 1922 Address 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Redeemer

DATE OF BURIAL

Oct 14 1922

20 UNDERTAKER

MRS. N. S. FINK,

FUNERAL DIRECTORS

1835 W. PRATT STREET.

Exact statement of OCCUR-
rence should be carefully supplied. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important.

14 1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE *68305*

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2143 Wilkens Ave.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George E. Spindler

(a) RESIDENCE. NO.

2143 Wilkens Ave.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *26* yrs. *10* mos. *15* ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 27-1895

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*26**10**15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Foreman (Tool Room)

(b) General nature of industry, business, or establishment in which employed (or employer)

Railroad

(c) Name of employer

B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Geo. Spindler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto., Co., Md.

12 MAIDEN NAME OF MOTHER

Annie Geisler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Annie Spindler, 2143 Wilkens Ave.

15

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 12* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from

Aug 1, 19*22*, to *Oct 12*, 19*22*,that I last saw him alive on *Oct 11*, 19*22*,and that death occurred, on the date stated above, at *5:30* a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Robert G. Hirsch, M. D.10/13/1922 Address *2157 Wilkens Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Cathedral Cemetery**Oct. 16* 19*22*

20 UNDERTAKER

ADDRESS

*Elmer W. Conklin**924 E. Eager St.*

mation should be carefully supplied. See instructions on back of certificates.

1141922

Burial Permit Clerk.

D. 68306

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68306

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

412 N. Carrollton St.

WARD) 18

2-FULL NAME

Celene Killian

(a) RESIDENCE NO.

412 N. Carrollton St.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

7

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug. 5th 1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

2

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John Killian

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Nichelene Damm

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Edward H. Rager 412 N. Carrollton St.

15

Filed

Robert F. HARTABER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13th 192217 I HEREBY CERTIFY, That I attended deceased from Aug 1st 1921, to Oct 13th 1922, that I last saw her alive on Oct 13th 1922, and that death occurred, on the date stated above, at 1.30 A. M.

The CAUSE OF DEATH* was as follows:

Mental Regeneration (duration) 1 yr 2 mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Ratt. J. Murroy, M. D.

10-13, 1922 (Address) 510 N. Vermont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

George J. Smith

1000

Exact statement of cause of death should be supplied. See instructions on back of certificates.

11-14-1922

Burial Permit Clerk

20.68307 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68307

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes* ST. *Ward*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME *Sister Mary Joseph*(a) RESIDENCE NO. *Dominican Convent*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Religious*6 DATE OF BIRTH (month, day, and year) *April 15 1872*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *50 yrs*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Religious*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Robert Pigeon*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Ellen Lee*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*

14

Informant (Address) *Sister Mary Joseph*

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 1 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Sept 17 1922 to Oct 1 1922*that I last saw (her) alive on *Oct 1 1922*and that death occurred, on the date stated above, at *12:45 p.m.*

The CAUSE OF DEATH* was as follows:

*Chronic & Subacute Nephritis - Uremia*CONTRIBUTORY (Secondary) *not known* (duration) yrs. mos. ds.*Cardiac failure* (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Urinal*(Signed) *W.C. Caldwell* M. D., 19 (Address) *St. Agnes Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

DATE OF BURIAL

Dominican Convent Cemetery Oct 3 1922

20 UNDERTAKER

ADDRESS

Wendell Duffel 378 N

Cause of death should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCURANCE of DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

20.68308 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68308

CERTIFICATE OF DEATH.

74-001
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Morris St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1125 Morris St. 16 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Unknown, 1857
(Month) (Day) (Year)

7-AGE,

65 yrs. mos. ds.

If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

I.A.

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER (State or Country),

Unknown

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Smith

(Address) 1125 Morris St

15-

Robert P. Harrison

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Feb 12, 1922
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

April 12 1921, to Feb 12 1922

that I saw him alive on Feb 12 1922,

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Robert Harrison

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Harrison M. D.

Feb 12 1922, 712 S. Park

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Laurel St

DATE OF BURIAL,

Oct. 15, 1922

20-UNDERTAKER

Chas. Brown & Son 108 W. Mount St

CAUSE OF DEATH in plain terms, so that it may be properly classified. List mentioned important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE *20.68309*

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1700 Carewell* ST.; *9* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1700 Carewell* St.; yrs. mos. *3* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

*White*5-SINGLE, *Single*
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

October 10, 1922, *1*.....
(Month) (Day) (Year)

7-AGE,

3 yrs. *3* mos. *3* ds.If LESS than 1 day,
....hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry, business,
or establishment in which
employed (or employer).....

9-BIRTHPLACE,

(State or Country), *1700 Carewell St.*10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER(State or Country), *Med*12-MAIDEN NAME
OF MOTHER13-BIRTHPLACE
OF MOTHER(State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Medford Murphy*(Address) *1700 Carewell St.*

15-

*Robert P. Garrison*Filed *17-1922*

191.

Burial Permit *Class* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

October 13, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Oct 10, 1922, to *Oct 13, 1922*,that I saw him alive on *October 13, 1922*,and that death occurred, on the date stated above, at *5 P* m.

The CAUSE OF DEATH* was as follows:

Immature birth about
6 1/2 months
(Duration).....yrs.....mos.....ds.CONTRIBUTORY
(Secondary)(Signed) *Hyman Westbrook* M. D.
October 13, 1922 (Address) *116 N. G. Street**State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES,
state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or
HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?.....Former or
usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

Baltimore County

DATE OF BURIAL,

Oct 14, 1922

20-UNDERTAKER

Robert J. Turner Inc *1442 Broadway*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

D. 68310

HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 255 Patapsco St. Westport, Md.)

2-FULL NAME Elizabeth Bender

(a) RESIDENCE NO. 255 Patapsco St Westport WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry G. Bender

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years 65 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Carl Dixon (Address) 182 W. Virginia Ave.

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 1922

17 I HEREBY CERTIFY that I attended deceased from Aug 29, 1922, to Oct 12, 1922, that I last saw h alive on Oct 11, 1922

and that death occurred, on the date stated above, at 4:00 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Cerebral embolism (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. M. Kieffer, M. D.

Oct 12, 1922 Address 2320 W. Virginia Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

London Park Cemetery Oct 14 1922

20 UNDERTAKER ADDRESS

J. Vander & Sons 1700 Fleet St

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Exact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

10.68311 HEALTH DEPARTMENT—CITY OF BALTIMORE CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 Hunan ST., 1 WARD)

2-FULL NAME

James M Gordon

(a) RESIDENCE NO.

225 Hunan ST. ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 19 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James

6 DATE OF BIRTH (month, day, and year) Sept 24 / 1868

7 AGE Years 54 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER James M Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ellen Keuring

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

Filed

19

Robert F. HARTLEY

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922 to Oct 13, 1922, that I last saw him alive on Oct 13, 1922, and that death occurred, on the date stated above, at 9:45 a.m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) yrs. 7 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray : Surgery

(Signed) Daniel J. G. M. D.
1922 (Address) 5325 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Philadelphia Pa. Oct. 14 1922
H. M. G. Schaeffer 1816 Mount

141922

D. 68312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68312

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital.

REGISTERED NO.

CITY OF BALTIMORE (No.

Lombard & Jones St.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Florence Snyder

(a) RESIDENCE. No.

4501 Eastern Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs.

mos.

ds.

How long in U. S., of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or ~~WIFE~~ of)

Joseph L. Snyder

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Louis Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary Floyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Joseph Snyder
4501 Eastern Ave

15

Filed

ROBERT E. HILL

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/13 1922

17

I HEREBY CERTIFY, That I attended deceased from

10/12 1922, to 10/13 1922

that I last saw him alive on 10/13 1922

and that death occurred, on the date stated above, at 11¹⁵ P. M.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal Ulcer

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

General Peritonitis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

If not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings.

(Signed)

Leon Fordon M. D.

19

(Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR INTERMENT

DATE OF BURIAL

Cedar Grove

Oct 16 1922

20 UNDERTAKER

ADDRESS

W. S. Marshall 3539 Fall Rd

Information should be carefully checked and corrected before filing. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

14 1922

12.68313 HEALTH DEPARTMENT—CITY OF BALTIMORE 12.68313

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Southern Hotel*

REGISTERED NO. C

CITY OF BALTIMORE NO. *Light & Redwood St.* ST. *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *German Campbell White*

(Residence in Baltimore: No. *New York City*

St.; yrs., mos. *for* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

October (Month) *1859* (Day) (Year)

7-AGE,

63 yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Publisher

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

New York

10-NAME OF FATHER,

John C White

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore Md

12-MAIDEN NAME OF MOTHER

Mary Williams

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs Alan Cole

(Address)

1207 N. Calvert St

15-

Robert P. Harrison

Filed

191

Registrar.

Burial Permit *0107*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 12, 1912 (Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest find that said deceased came to *his* death (topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral aneurysm

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Wm. D. M. D.* (Coroner.)

Oct. 13, 1912 (Address) *26 S. 7th St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place *Greenmount* In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Greenmount Cem

Oct 14, 1912

20-UNDERTAKER

ADDRESS

Wm. D. M. D.

26 S. 7th St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.68314

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.68314

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph Hospital* ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *732 N. Wolfe St.*St.; *40* yrs., *0* mos., *0* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

Married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH

Oct 10, 1926
(Month) (Day) (Year)

7-AGE

46 yrs., *3* mos., *0* ds.

If LESS than 1 day,

...hrs. or ...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or Country)

10-NAME OF FATHER

Wm. C. Evans

11-BIRTHPLACE OF FATHER

(State or Country)

12-MAIDEN NAME OF MOTHER

Mary E. DeWyer

13-BIRTHPLACE OF MOTHER

(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

14 1922

Robert P. Harrison,

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Oct 13, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Oct 12, 1922, to Oct 13, 1922,*that I saw him alive on *Oct 13, 1922,*and that death occurred, on the date stated above, at *5:46 P.M.*

The CAUSE OF DEATH* was as follows:

Shock following operation for gall stones
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

Cholelithiasis

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. A. Schenck* M. D.*Oct 13, 1922* (Address) *St. Joseph's Hosp.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.

DATE OF BURIAL

*New Cathedral**Oct. 14, 1922*

20-UNDERTAKER

ADDRESS

*Geo. M. Smith & Son**811 N. Wolfe*

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

2-FULL NAME

Frisby McNann(a) RESIDENCE NO. Unknown
(Usual place of abode)ST. 76 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 1858
7 AGE Years Months Days If LESS than 1 day, hrs or min. 64 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Hospital Records, Municipal Hospital.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 1922

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1921 to October 12, 1922.
that I last saw him alive on October 12, 1922.
and that death occurred, on the date stated above, at 8:10 P.M.
The CAUSE OF DEATH* was as follows:

Chronic nephritisCONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Dr. J. H. H. H.

M. D.

10/13/22 Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Fessop Cemetery

DATE OF BURIAL

Oct 15 1922

20 UNDERTAKER

Wm L Brooks

ADDRESS

Sparks St

tion should be carefully supplied. Exact statement of occurrence should be carefully supplied. Exact statement of occurrence should be carefully supplied. Exact statement of occurrence should be carefully supplied.

1922

Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

268316

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 76 WARD)2. FULL NAME Lucy Snellings(a) RESIDENCE NO. Unknown(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 7-7-18377 AGE Years Months Days If LESS than 1 day, hrs or min. 84 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant Hospital Records,
(Address) Municipal Hospital.15 Filed Robert P. Harrison,
19 22 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 192217 I HEREBY CERTIFY, That I attended deceased from August 15, 1922, to October 12, 1922, that I last saw him alive on October 12, 1922, and that death occurred, on the date stated above, at 12:30 P.M.
The CAUSE OF DEATH* was as follows:Senility; arteriosclerosis
Myocardial degeneration
(duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Insufficiency (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles M. Meier M. D.19/10/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

St. Marys Amden

DATE OF BURIAL

Oct 16 1922

ADDRESS

5028 Nod

20 UNDERTAKER

Wm Cook

Exact statement of DEATH should be carefully supplied. Not to be used in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

DEC 14 1922

Burial Permit

D. 68317

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68317

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Reggore ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1404 Reggore ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6-1922

7 AGE Years 5 Months 7 Day If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work name

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

10 NAME OF FATHER H. Butler

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Ethel Jackson

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mrs L. Jackson (Address) 512 Brockton St

15 Filed 14 1922 19 Robert P. HARRISON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-13 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1922, to Oct 13, 1922, that I last saw him alive on Oct 13, 1922, and that death occurred, on the date stated above, at 6 PM m.

The CAUSE OF DEATH* was as follows:

Ac Gastroenteritis

CONTRIBUTORY (Secondary) (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings (Signed) W. A. Thell M. D.

1919 (Address) Longfellow

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Peter's Cemetery October 14, 1922

20 UNDERTAKER ADDRESS

Mrs. Katie R. Williams 1114 W. Saratoga St.

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

68318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 Sipple Ave. Gardenville ST. 49 WARD)

2-FULL NAME

Morris O. Ferguson(a) RESIDENCE NO. 112 Sipple Ave Gardenville ST. 49 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. D68318

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Ida May Ferguson

6 DATE OF BIRTH (month, day, and year)

July 13th 1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

483

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Brass Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

Ship Yard

(c) Name of employer

Bethlehem Ship Bldg Co

9 BIRTHPLACE (city or town) (State or country)

Frederick Md.Maryland

10 NAME OF FATHER

William Ferguson

11 BIRTHPLACE OF FATHER (city or town)

Balto.

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Matilda Figgins

13 BIRTHPLACE OF MOTHER (city or town)

Balto.

(State or country)

Maryland

14

Informant

(Address)

Ida May Ferguson112 Sipple Ave Gardenville

15

Filed

OCT 15 1922

ROBERT R. MAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 13 1922

17

I HEREBY CERTIFY, That I attended deceased from July 1st 1922 to Oct. 13th 1922, that I last saw him alive on Oct. 12th 1922, and that death occurred, on the date stated above, at 5:40 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lungs.

(duration)

9 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration)

3 yrs. 3 mos. ds.

18 Where was disease contracted

if not at place of death?

Inkheim.

Did an operation precede death?

No Date of no

Was there an autopsy?

no

What test confirmed diagnosis?

Labatory as far as possible

(Signed)

Thos. B. Bledsoe M. D.

, 19 (Address)

1014 17th St. Bay City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore Cemetery Oct 17 1922
Fred. Cassah

Information should be carefully supplied. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

068319 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

H. Hospital

CITY OF BALTIMORE: (No

Monument St. 1

ST.: ☒

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

m. Jacob Hurwitz

(a) RESIDENCE. NO.

248 Washington St.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1905

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School-Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Sam Hurwitz

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

May Jankovitch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 5th St

15

Filed

1922

ROBERT R. KRAUTER

Baptist Pottery Works

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/13

1922

17

I HEREBY CERTIFY, That I attended deceased from

October 8, 1922, to Oct 13, 1922

that I last saw him alive on Oct 13, 1922

and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Appendix Abscess

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes

Date of

Oct 11

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

David A. Ruben, M. D.

10/13, 1922 (Address)

Hebrew Group

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Northmen Civil Cem

10/15 1922

Jack Lewis 1439 5th St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Randolph J. Richards

6 DATE OF BIRTH (month, day, and year)

February 8th 1851

7 AGE

Years

Months

Days

LESS than 1 day, hrs. or min.

71

8

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Co Md

10 NAME OF FATHER

John James

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katherine Heller

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

Randolph J. Richards

(Address)

Bellona & Hitting ave

15

Filed

OCT 15 1922

BURIAL PERMIT

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct - 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept - 1922

to

Oct - 13 1922

that I last saw him alive on

Oct - 13 1922

and that death occurred, on the date stated above, at 9.50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall Bladder

(duration)

yrs.

5+

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

—

Did an operation precede death?

Yes

Date of

Aug. 14 1922

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

M. Edwin Porter

M. D.

10/14 1922

(Address)

422 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Harford

20 UNDERTAKER

George Schilling & Sons

DATE OF BURIAL

Oct 17 1922

ADDRESS

126 E. Main St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 2940 Cedar Ave. ST. 13 WARD

2-FULL NAME

Alice J. Bressler

(a) RESIDENCE NO.

2940 Cedar Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Edward R. Bressler

6 DATE OF BIRTH (month, day, and year)

Oct 13 1867

7 AGE

55

Years

Months

4

Days

0

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

York Co. Pa.

10 NAME OF FATHER

Aaron Kinnard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Louise Gerbick

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14 Informant (Address)

Edward R. Bressler 2940 Cedar Ave.

15

Filed

OCT 15 1922

ROBERT R. KRAUTER Registrar

Burial Point

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1921 to Oct 14 1922 that I last saw him alive on Oct 13 1922 and that death occurred, on the date stated above, at 7:35 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatic Ulcer
Chronic valvular heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) R. W. D. M. D.

Address 2024 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

St. John's New Freedom 11/17 1922

20 UNDERTAKER

J. Walter Davis

ADDRESS

3307 Ridge St.

68322

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68322

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 Patterson Pl. Ave. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Cornelia Amoss

(a) RESIDENCE NO.

1926 Patterson Pl. Ave. 8 WARD

(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph Amoss Aug 10, 1867

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

58 2 3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George Sweaver

11 BIRTHPLACE OF FATHER (city or town)

Unknown

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

Unknown

(State or country)

14

Informant (Address)

George Rosby 1926 Patterson Pl. Ave.

15

Filed

OCT 15 1922

ROBERT H. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13, 1922.

17 I HEREBY CERTIFY, That I attended deceased from

Sept 11, 1922, to Oct 13, 1922.

that I last saw her alive on Oct 9, 1922.

and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edw. H. Caslake, M. D.

10/13, 1922 (Address) 321 N. Totten Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Parkwood Cemetery

20 UNDERTAKER

Chenoweth & Son 3617 Fall Road

Exact statement of OCCUR-
rence should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *563 E 38th*)ST., *9* WARD)

2. FULL NAME

Robert V Ripple

(a) RESIDENCE NO.

563 E 38th

ST., _____ WARD _____

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *1* yrs *8* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 1st 1921

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*1**8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore Md.*

10 NAME OF FATHER

*John M Ripple*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Baltimore Md.*

12 MAIDEN NAME OF MOTHER

*Agness McEntyre*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Baltimore Md.*

14

Informant
(Address)*John M. Ripple
563 E 38th St*

15

Filed

*Oct 15 1922*ROBERT R. MAUTER
Registrar

Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 13 1922*

17

I HEREBY CERTIFY, That I attended deceased from

Oct 13 1922 to *Oct 13 1922*that I last saw him alive on *Oct 13 1922*and that death occurred, on the date stated above, at *9 P. m.*

The CAUSE OF DEATH* was as follows:

*broncho pneumonia over*CONTRIBUTORY (Secondary) *Oedema* (duration) yrs. mos. ds. *7 mos 1 ds.*18 Where was disease contracted
if not at place of death?Did an operation precede death? *no* Date of _____Was there an autopsy? *no*What test confirmed diagnosis? *Clinical* M. D.(Signed) *James M Keaton*
(Address) *200 E Charles*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral

DATE OF BURIAL

10-16 1922

20 UNDERTAKER

E & B Harris

ADDRESS

*115 E West St*Exact statement of OCCUR-
rence should be carefully supplied. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 S. Patterson Ave ST., 1 WARD)2-FULL NAME Harry R. Coomer(a) RESIDENCE NO. 320 S. Patterson Ave ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

maleWhitemarried

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofLaura V. Coomer6 DATE OF BIRTH (month, day, and year) March 25, 1880

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.42617

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Clerk9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

Geo. Coomer

11 BIRTHPLACE OF FATHER (city or town)

Ind

(State or country)

12 MAIDEN NAME OF MOTHER

Elmina E. Pross

13 BIRTHPLACE OF MOTHER (city or town)

Balto

(State or country)

14

Informant
(Address)Laura V. Coomer
320 S. Patterson Ave

15

Filed

735191100ROBERT H. PASQUER
Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 12 192217 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1920, to Oct 12, 1922.that I last saw him alive on Oct 12, 1922.and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 1 yrs. 2 mos. 4 ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel L. Fisher, M. D., 19 (Address) 3325 Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVING

20 UNDERTAKER

Mt. Olivet
Funkhouser & FunkhouserOct 16 1922ADDRESS 1739Eager

Exact statement of OCCURRENCE should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST. 1 WARD)

2-FULL NAME

Agnes Reis

(a) RESIDENCE NO.

2206 Fleet St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12 19 22

17 I HEREBY CERTIFY, That I attended deceased from September 20 22, to Oct. 12 19 22.

that I last saw her alive on October 12 19 22.

and that death occurred, on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

9/13, 1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1889

7 AGE

33

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Maryland

10 NAME OF FATHER

J.H. Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Hospital Records,

Municipal Hospital,

ROBERT R. RAUTER,

15

Filed

OCT 15 1922

Bridal Parlor

Exact statement of occurrence. Information should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Exact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3714 Forest Park Ave. ST. 15 WARD)

2-FULL NAME

Eugene Francis Fraunie

(a) RESIDENCE NO.

3714 Forest Park Ave. ST. 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 15th 1914

7 AGE

8

Years

Months

Days

If LESS than 1 day... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore10 NAME OF FATHER Frank H. Fraunie

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto12 MAIDEN NAME OF MOTHER Margaret Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Frank H. Fraunie (father)
3714 Forest Park Ave

15

Filed

19

ROBERT R. MAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 19 2217 I HEREBY CERTIFY, That I attended deceased from Oct 13 19 22 to Oct 13 19 22that I last saw him alive on Oct 13th 19 22 and that death occurred, on the date stated above, at 2:07 m.

The CAUSE OF DEATH* was as follows:

Sarcoma Tibia (left)(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

None(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1922Was there an autopsy? NoWhat test confirmed diagnosis? Pathological Tissue Ex.(Signed) Robert W. Johnson M. D., 19 (Address) K. E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Holy Redeemer Cem. 10/16 19 22

20 UNDERTAKER

Chas. H. Evans & Son 1180 Mt Royal Ave

DATE OF BURIAL

ADDRESS

D68328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single,
Married,
Widowed,
or Divorced.
(Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER.
(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER.
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

OCT 15 1922

ROBERT R. KRAUTER

Bureau of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an investigation
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said investigation find that said deceased came to death
(Inquest, autopsy or inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull & Foramen
Anomalous Streets Case
Collection

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James A. Pugh M. D.

(Coroner)

Oct 15 1922 (Address) 200 E. Charles

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

CO-UNDERTAKER

ADDRESS

Cathedral Ceme. 10/18/22
Chas. J. Wane & Son 118 West Royal Ave

D 68329 HEALTH DEPARTMENT—CITY OF BALTIMORE *D 68329*

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *711 Arlington av* ST. *27* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Michael M. Mahon*

(Residence in Baltimore: No. *711 Arlington av* St. *65* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE, *Widowed*, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH, *Oct 29, 1862*
(Month) (Day) (Year)

7-AGE, *70* yrs. mos. ds. 11 LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Ireland.*

10-NAME OF FATHER, *Martin M. Mahon*
11-BIRTHPLACE OF FATHER, *Ireland*
12-MAIDEN NAME OF MOTHER, *Margt. Henry*
13-BIRTHPLACE OF MOTHER, *Ireland.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Annie Walsh*(Address) *711 Arlington*15- *OCT 15 1922* *ROBERT N. KRAUTER*Filed. 191. *Charles F. Morris Registrar.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 13, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 5, 1922*, to *Oct 13, 1922*, that I saw him alive on *Oct 12, 1922*, and that death occurred, on the date stated above, at *11:45 a.m.*

The CAUSE OF DEATH* was as follows:

Apoplexy
(Duration) yrs. mos. ds.

CONTRIBUTORY *Chronic Interstitial Nephritis*
(Secondary)

(Duration) yrs. mos. ds.
(Signed) *John S. Farley* M. D.
10/13, 1922 (Address) *2522 Greenmount*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

New Calhoun *Oct 16, 1922*

20-UNDERTAKER ADDRESS

E. A. Wiedefeld *501 E 22nd St*

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1 PLACE OF DEATH

CITY OF BALTIMORE (No.

2 FULL NAME

(Residence in Baltimore: No.

ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

15.

Filed

191

ROBERT R. MAUTER

Barla Perma

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17. I HEREBY CERTIFY, That I attended deceased from

that I saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory (SECONDARY)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted.

If not at place of death?

Former or

usual residence

19. PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20. UNDERTAKER

ADDRESS

68331

HEALTH DEPARTMENT—CITY OF BALTIMORE

68331

CERTIFICATE OF DEATH.

1-001

868331

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balts. General Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Grace Ireland

(a) RESIDENCE NO.

1911 E. Federal St. ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____

ds. _____ How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleWhiteMarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Noah Ireland

6 DATE OF BIRTH (month, day, and year)

Dec. 23 - 1881

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

4097

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House mfr

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

George Parlett

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Kate Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Noah J. Ireland
1911 E. Federal

15

Filed

19

ROBERT H. MAUTER

1912 Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

9/2, 1922 to 10/14, 1922.that I last saw her alive on Oct 14, 1922.and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration)

yrs. 2 mos. _____ ds. _____

CONTRIBUTORY (Secondary)

(duration)

yrs. _____ mos. _____ ds. _____

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death?

No Date of _____

Was there an autopsy?

No

What test confirmed diagnosis?

Widal. Culture

(Signed)

19 (Address)

R. H. Mole
5. Bal. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

London Park
Mr. CookOct 17 1922
502 E. North

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.: 16 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Pfr yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F*4 COLOR OR RACE *W*5 Single, Married, Widowed,
or Divorced (write the word)*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

OCT 15 1922

ROBERT L. KAUTER
Registrar

Bertel Permitt Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10-13 1922

17

I HEREBY CERTIFY, That I attended deceased from

1922, to 10-13, 1922

that I last saw him alive on 10-13, 1922

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast
*Carcinomatous*CONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

10-13 1922 Address

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

Oct 16, 1922

20 UNDERTAKER

ADDRESS

Wm Cook, 502 E. North Ave.

Information should be carefully supplied. Age should be given in years, months, and days. Cause of death in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

268333

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 675 W Barre

ST.: 22 WARD)

2-FULL NAME ALX FIERSUK

(a) RESIDENCE. No. 675 W Barre
(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15th 1921

7 AGE - Years 10 Months 28 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore M.D.

10 NAME OF FATHER Jekup Fiersuk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER C. Senkus

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Lithvania

14 Informant Jekup Fiersuk (Address) 675 W Barre Street

15 Filed

19

Registrar

OCT 16 1922

ROBERT R. KEAULAH

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 3 1922 to Oct 13 1922 that I last saw her alive on Oct 12 1922

and that death occurred, on the date stated above, at 11-30. p.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Harry Boyd M. D.

19

(Address)

602 Washington Blvd

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Loudon Park

Oct. 15th 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas 425 S Paca St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (NO.

ST. 6 WARD)

2-FULL NAME

John Weiss

(a) RESIDENCE NO.

131 North Chapel

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Cecelia Weiss

6 DATE OF BIRTH (month, day, and year)

Oct. 27 1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Driver of Wagon

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Andrew Weiss

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

Mrs. Cecelia Weiss 131 N. Chapel St.

15

Filed

OCT 16 1922

ROBERT R. KRAUTH

Registrar

Burial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 3 1922, to Oct. 15 1922.

that I last saw him live on Oct. 15 1922.

and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum, Hydrate.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

Carcinoma

(duration) 1 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 9 1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Pessagno M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Redeemer

Oct. 19 1922

20 UNDERTAKER

ADDRESS

J. J. Kerr 150 N. Luzerne Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15 Filed

226191

130

ROBERT R. KRAUTER

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/14 1922

17

I HEREBY CERTIFY, That I attended deceased from

10/12, 1922, to 10/14, 1922,

that I last saw him alive on 10/14, 1922,

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Enteric Intoxication

(duration) yrs. 2, mos. ds.

CONTRIBUTORY
(Secondary)

Tuberculosis

(duration) yrs. mos. 14, ds.

18 Where was disease contracted
if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Clinical findings

(Signed)

Leon Freedom

M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Cross Cemetery

Oct. 16 1922

20 UNDERTAKER

ADDRESS

George J. Rutli 735 Haford

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Ignace Hospital ST. 9 WARD)2-FULL NAME Mrs. Conrad Rubin(a) RESIDENCE NO. 1230 Federal St. ST. 11 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Rubin6 DATE OF BIRTH (month, day, and year) June7 AGE 63 yrs. Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD10 NAME OF FATHER Do not know11 BIRTHPLACE OF FATHER (city or town) (State or country) do not know12 MAIDEN NAME OF MOTHER do not know13 BIRTHPLACE OF MOTHER (city or town) (State or country) do not know14 Informant Mrs. E. L. Rubin (Address) 1230 Federal St.15 Filed 1922 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 13 19 2217 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 19 22 to Oct. 13, 19 22that I last saw him alive on Oct. 13, 19 22and that death occurred, on the date stated above, at 11:53 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Pancreas
membrane of chest & glands
neck(duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. Broncho-pneumonia18 Where was disease contracted if not at place of death? HomeDid an operation precede death? Yes Date of Sept 1922Was there an autopsy? NoWhat test confirmed diagnosis? Microscopic(Signed) W. C. Caldwell, M. D., 19 (Address) St. Ignace Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery DATE OF BURIAL Oct 18 19 22

20 UNDERTAKER

George J. Rull ADDRESS 1735 Harford Ave.

Exact statement of occupation should be carefully supplied. Cause of death should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

68337

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Hebrew Hospital* St. *6* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *126 Jackson Place* St. *25* yrs. *10* mos. *25* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH

(Month)

(Day)

1821 (Year)

7-AGE

51 yrs. 10 mos. 25 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER.
(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Filed

OCT 16 1922

ROBERT R. KRAUTER

Perital Record

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

(Month)

(Day)

1922 (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)(Signed) *J. H. Patterson* M. D.
(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Hebrew Hospital *10/16*

20-UNDERTAKER.

ADDRESS

Jack Lewis 1439 E. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Beatrice Brown

(a) RESIDENCE NO.

906 W. Bolton st.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

FemaleColoredSingle

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

school-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland10 NAME OF FATHER Samuel Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

West Virginia12 MAIDEN NAME OF MOTHER Maggie Beckett

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Hospital RecordsROBERT H. KRAUTER

15

Filed

OCT 16 1922Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 9, 1922 to Oct. 14, 1922.that I last saw her alive on Oct. 14, 1922.and that death occurred, on the date stated above, at 10.15 a.m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis(duration) yrs. 10 mos. ds.CONTRIBUTORY Spontaneous pneumonia (Secondary) (duration) yrs. 1 mos. 5 ds.18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Sp. in sputum, X-ray

(Signed)

Francis J. Delaplace M. D.

10-14-22

(Address)

Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Mt Auburn or Oct

20 UNDERTAKER

ADDRESS

Amel Lorton

Exact statement of Occurrence should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Mr Adams

268339 HEALTH DEPARTMENT—CITY OF BALTIMORE **268339**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. *Murphy Hospital* St. *4* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mr. Adams*
(Residence in Baltimore: No. *Orange Court, 17-* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX. <i>male</i>	4-COLOR OR RACE. <i>Col</i>	5-Single, Married, Widowed, or Divorced. (Write the word.) <i>Married</i>	16-DATE OF DEATH. <i>Oct 10</i> , 192 <i>2</i> (Month) (Day) (Year)	
6-DATE OF BIRTH. <i>Don't know</i> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said and that said deceased came to <i>this</i> death on the day stated above. The CAUSE OF DEATH* was as follows: <i>Stab wound in abdomen</i>	
7-AGE. <i>40</i> yrs. mos. ds. If LESS than 1 day, hrs. or min.?			CONTRIBUTORY (Secondary) <i>Act by Robert Kidd</i> (Duration) yrs. mos. ds. (Signed) <i>H. K. Grounch</i> M. D. (Coroner.) <i>10-16</i> , 192 <i>2</i> (Address) <i>117 W. Saratoga St.</i>	
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer). <i>Laborer</i>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
9-BIRTHPLACE. (State or Country). <i>Bald City</i>			18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?	
PARENTS	10-NAME OF FATHER. <i>Don't know</i>		Former or usual residence	
	11-BIRTHPLACE OF FATHER. (State or Country).		19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.	
	12-MAIDEN NAME OF MOTHER.		<i>St. Catharine Cemetery</i> <i>10/16/22</i>	
	13-BIRTHPLACE OF MOTHER. (State or Country).		20-UNDERTAKER. ADDRESS	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>H. K. Grounch</i> (Address) <i>117 W. Saratoga St.</i>				
15- Filed <i>OCT 16 1922</i> <i>ROBERT R. KRAUTER</i> Registrar. <i>Barclay Permitt Black</i>				

D68340 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1252 Barnum Ave. ST., 9 WARD)2-FULL NAME Barbara Hohl(a) RESIDENCE No. 1252 Barnum Ave. ST., 9 WARD
(Usual place of abode) (If non-resident give city or town and State)Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hohl6 DATE OF BIRTH (month, day, and year) April 14, 18617 AGE Years 61 Months 6 Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Michael Sommer11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany14 Informant Charles Hohl
(Address) 1252 Barnum Ave.15 Oct 16 1922 ROBERT R. MAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14, 192217 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1922 to Oct 14, 1922that I last saw her alive on Oct 14, 1922and that death occurred, on the date stated above, at 9:15 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach(duration) 9 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman, M. D., 19 (Address) 2558 Harbor Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Schwartz Cemetery DATE OF BURIAL Oct. 17, 192220 UNDERTAKER Mrs. John H. TengelADDRESS 801 W. Fayette St.

Burial Permit Clerk

tion should be carefully supplied. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

N. B.—Every item of information should be carefully supplied. Accurate statement of OCCUPATION is very important. See instructions on back of certificate.

68341 HEALTH DEPARTMENT—CITY OF BALTIMORE 68341
188-003

PLACE OF DEATH
CITY OF BALTIMORE (No. *St Agnes Hospital* ST. *20* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
FULL NAME *William H. Reed*
(Residence in Baltimore: No. *608 S. Payson St.* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Single* (Write the word.)
6-DATE OF BIRTH, *Aug. 26, 1916*
(Month) (Day) (Year)

7-AGE, *6* yrs., *1* mos., *17* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *School Boy*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto. Md*

10-NAME OF FATHER, *John H. Reed*

11-BIRTHPLACE OF FATHER (State or Country), *Md*

12-MAIDEN NAME OF MOTHER *Bertha Green*

13-BIRTHPLACE OF MOTHER (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Bertha Reed*
(Address) *608 S. Payson St.*

15- *OCT 16 1922* *ROBERT R. KRAUTER*
Filed..... 191..... Registrar *Marcel Fort*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 13, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Investigation* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Investigation* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:
fracture base of skull
fracture base of skull
accident

(Duration)..... yrs..... mos..... ds.
CONTRIBUTORY *Rail - to auto* (Secondary)
(Duration)..... yrs..... mos..... ds.

(Signed) *James W. Fulton* M. D. (Coroner.)
Oct. 14, 1922 (Address) *200 E. Chase St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place *Payson St* In the of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....
77 2020 Cap St
Former or usual residence *608 S. Payson*

19-PLACE OF BURIAL OR REMOVAL, *Int Oliver Cem* DATE OF BURIAL, *Oct 16, 1922*

20-UNDERTAKER *Miss J. M. Trefel & Son* ADDRESS *801 W. Fayette*

N. B.—Every item of information on this form should be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

268342 HEALTH DEPARTMENT—CITY OF BALTIMORE 268342
CERTIFICATE OF DEATH. 90
Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 381 S. Poppleton St. 18 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME John P. Shanahan
(Residence in Baltimore: No. 381 S. Poppleton St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE White	5-Single, Married, Widowed, or Divorced Married
6-DATE OF BIRTH Don't Know		
7-AGE 56 yrs. mos. ds.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Saloon Keeper		
9-BIRTHPLACE (State or Country) Baltimore City		
PARENTS	10-NAME OF FATHER John Shanahan	
	11-BIRTHPLACE OF FATHER (State or Country) Ireland	
	12-MAIDEN NAME OF MOTHER Julia Quinn	
	13-BIRTHPLACE OF MOTHER (State or Country) Ireland	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sarah Shanahan
(Address) 381 S. Poppleton St.

15- OCT 16 1922
Filed BY ROBERT R. MAUTER
Burial Permit Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Sudden Disease of the Heart
(Duration) 4 five miles ds.
CONTRIBUTORY (Secondary) Don't Know
(Signed) J. J. Gorman M. D.
(Coroner)
10-14 1922 (Address) 117 W. Swanton St.
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
New Cathedral Cemetery Oct 17 1922
20-UNDERTAKER John J. Gorman
Address 117 W. Swanton St.

158924 HEALTH DEPARTMENT—CITY OF BALTIMORE

158924 068343 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 068343) JOHNS HOPKINS HOSPITAL, 71 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

John J. Gallagher,
907 W. Barre St. City

WARD

(If non-resident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced

HUSBAND of

Agnes Gallagher (wife)

6 DATE OF BIRTH (month, day, and year) March 1, 1880.

7 AGE 42 Years 7 Months 12 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Hugh Gallagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Susan Cotton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1922, to Oct 13, 1922.

that I last saw him alive on Oct 13, 1922, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, Uremia
Hypertension

CONTRIBUTORY (Secondary) Uremia - Bronchopneumonia (duration) 1 yrs. ? mos. ds. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Barker Andrews, M. D. 10/14/22 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery Oct 18, 1922.

20 UNDERTAKER John J. Cowan & Son ADDRESS 29 Cowan St. Hallwood St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *610 Chestnut Hill Ave* ST.: *9* WARD)

2-FULL NAME

Mary A. Walton

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

610 Chestnut Hill Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. mos. ds. How long in U. S., if of foreign birth? *74* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Alexander S. Walton*

6 DATE OF BIRTH (month, day, and year)

July 10, 1839

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*83**3**4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*County Wicklow,
Ireland*

10 NAME OF FATHER

William Sherwood

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary A. Sherwood

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant
(Address)*(Miss) Berrie H. H. H.
612 Chestnut Hill Ave*

15

Filed

19

*ROBERT R. KRAUTH**Barial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 14, 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Oct. 11, 1922, to Oct. 14, 1922,*that I last saw her alive on *Oct. 14, 1922,*and that death occurred, on the date stated above, at *7:45 P. M.*

The CAUSE OF DEATH* was as follows:

Acute Bronchitis(duration) yrs. mos. *4* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of *-*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *C. A. Steeuter* M. D., 19 (Address) *3949 Greenmount Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*St. Agnes Cemetery
Mrs. Addie Walker Oct 16 1922*

20 UNDERTAKER

ADDRESS

723 W Lafayette Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH CARE. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

268345- HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 7 WARD)

2-FULL NAME

Haywood Johnson

(a) RESIDENCE No. 1019 N. Durham st.

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident, give city or town and State)

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Helen Johnson

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE Years 38 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER Benj. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Informant Hospital Records (Address) M. T. H.

15

Filed OCT 15 1922 ROBERT B. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 5, 1922, to Oct. 12, 1922,

that I last saw him alive on Oct. 12, 1922,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Spontaneous pneumothorax (Secondary) (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray in sputum

(Signed) Francis J. Adair, M. D.

10-13-22 (Address) Municipal Tub. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Int. Aurlen Cemetery Oct 16 1922

20 UNDERTAKER

Mrs. Robert A. Elliott Ashland Ave

D68346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68346

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2110 Frederick St. Ward 20)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Jura Wienecks(Residence in Baltimore: No. 2110 Frederick St.; yrs., 50 mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White5-Single,
Married,
Widowed,
or Divorced,
(Write the word.)
Single

6-DATE OF BIRTH

Jan. 5th 1858
(Month) (Day) (Year)

7-AGE

64 yrs. 9 mos. 7 ds.If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work Workin A Can.
- (b) General nature of industry, business, or establishment in which employed (or employer) ing House.

9-BIRTHPLACE,
(State or Country).Germany10-NAME OF
FATHERUnknown11-BIRTHPLACE
OF FATHER,
(State or Country).Germany12-MAIDEN NAME
OF MOTHERBehn13-BIRTHPLACE
OF MOTHER,
(State or Country).Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christian Schlutter(Address) 170 S Calverton Road

15-

Filed

192

ROBERT H. KRAUTER,Notal Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Oct 3 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said inquest, au-inquest find that said deceased came to death
topsy or inquiry on the day stated above.

The CAUSE OF DEATH* was as follows:

apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) James M. Kenton M. D.Oct 14 1922 (Address) 2008 Ches St
(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Park Cemetery Oct. 16 19

20-UNDERTAKER

ADDRESS

George L. Schwab2101 Fredk. Ave

N. B.—Every item of information should be in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S. Bond ST., 3 WARD)2-FULL NAME George Hoffmann(a) RESIDENCE NO. 520 S. Bond ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of Elizabeth Hoffmann (or) WIFE of6 DATE OF BIRTH (month, day, and year) Nov 21, 18397 AGE Years 82 Months 10 Days 23 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Basket Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Veit Hoffmann11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known14 Informant Kurtz Holland (Address) 520 S. Bond St.15 OCT 16 1922 ROBERT R. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 192217 I HEREBY CERTIFY, That I attended deceased from July 5, 1922, to Oct 14, 1922, that I last saw him alive on Oct 13, 1922, and that death occurred, on the date stated above, at 8 Am m.

The CAUSE OF DEATH* was as follows:

General Debility (Senility)
(Senile deg. arteriosclerosis)(duration) 3 yrs. _____ mos. _____ ds.CONTRIBUTORY (Secondary) Coronary atherosclerosis
(duration) _____ yrs. _____ mos. 10 ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? noWhat test confirmed diagnosis? ✓(Signed) Dr. Peterson, M. D., 19 _____ (Address) 1256 1/2 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Evangelical bur.DATE OF BURIAL Oct 17 192220 UNDERTAKER H. Sander & SonADDRESS 1210 Pk. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PHYSICIANS SHOULD STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

068348 HEALTH DEPARTMENT—CITY OF BALTIMORE 068348 31 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 S. Necker Ave ST.: 1 WARD)

2-FULL NAME

Frank Sliwinski

(a) RESIDENCE. NO.

1016 S. Necker Ave

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 23 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

WIFE ofMartha

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.43

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Building works

(c) Name of employer

Baltimore City

9 BIRTHPLACE (city or town) (State or country)

Russian-Poland

10 NAME OF FATHER

Teofil

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russian

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

RussianPoland

14

Informant

(Address)

Michael Sliwinski1016 S. Necker Ave

15

Filed

10-16-1922ROBERT H. [illegible]

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14-1922

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1922, to October 9, 1922.that I last saw him alive on October 9, 1922.and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

Bronchial asthma(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Signs(Signed) J. B. Bronnshar, M. D.10-14-1922 Address 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St StanislausOct 171922

20 UNDERTAKER

ADDRESS

John M. Weber1803 Bank

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Probably a Tubercular
Bronchial Asthma*

Physician should state EXACTLY: Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D68349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D68349
101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 S Monfort St., WARD)

2-FULL NAME

Rita Bosley

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

723 S Monfort St., WARD

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 19, 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER

Joseph R Bosley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Frances Kuroski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14

Informant (Address)

Frances Bosley 723 S. Monfort St.

15

Filed OCT 16 1922

ROBERT H. MAUTER, Registrar

Bacial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1922, to Oct 14, 1922

that I last saw him alive on Oct 14, 1922

and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Sohn Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Acute Cardiac Disease

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Rogers, M. D.

(Address) 1922 S. E. 1st St. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Oct 16 1922

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bank St.

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68350 HEALTH DEPARTMENT—CITY OF BALTIMORE 89 2 68350
CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH Franklinton, Md.
City of BALTIMORE: (No. Franklinton Hotel, St. 78 ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Charles Philip Gehringer
(Residence in Baltimore: No. Franklinton, Md. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male	4-COLOR OR RACE, White	5-Single, Married, Widowed, or Divorced, Married (Write the word.)
6-DATE OF BIRTH, October 10th 1874 (Month) (Day) (Year)		
7-AGE, 48 yrs. 0 mos. 2 ds.		If LESS than 1 day, ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, ... Proprietor of (b) General nature of industry, business, or establishment in which employed (or employer), ... Confectionery Store		
9-BIRTHPLACE, (State or Country), ... Baltimore, Md.		
PARENTS:	10-NAME OF FATHER, ... William Gehringer	
	11-BIRTHPLACE OF FATHER, ... Germany (State or Country),	
	12-MAIDEN NAME OF MOTHER, ... Catherine Geis	
	13-BIRTHPLACE OF MOTHER, ... Baltimore, Md. (State or Country),	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Pauline P. Gehringer
(Address) Franklinton, Md.

15- OCT 16 1922 ROBERT R. KRAUTER, Registrar.
Funeral Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 12th 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Angina pectoris
(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) ...
(Signed) J. T. Hennessy M. D. (Coroner)
Oct. 13 1922 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the ... State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, ... DATE OF BURIAL, ...
London Park Cem Oct 16 1922
FUNERAL TAKEN BY, ... ADDRESS, ...
Joseph B. Cook 1003 N. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, No.

1729 Wilkens Ave. 44

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mildred May Harris

(a) RESIDENCE, No.

1729 Wilkens Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Lifetime

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

✓

6 DATE OF BIRTH (month, day, and year)

July - 11 - 1889

7 AGE

Year

Months

Days

If LESS than

1 day, hrs.

or min.

33

33

3

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sewing Machine Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

Operating Sewing Machine

(c) Name of employer

Not employed during year

9 BIRTHPLACE (city or town)

Balto. Md.

(State or country)

10 NAME OF FATHER

Robert T. Harris

11 BIRTHPLACE OF FATHER (city or town)

Halifax Co.

(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Mary E. Gittings

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Maryland

14

Informant

Robert T. Harris

(Address)

1729 Wilkens Ave.

15

Filed OCT 16 1922

ROBERT H. MAUTER

Registrar

Burial Permit Desk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 14 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 29, 1922, to Oct 14, 1922,

that I last saw her alive on Oct. 13, 1922.

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) Over 7 mos. ✓ ds.

CONTRIBUTORY

(Secondary)

(duration) ✓ yrs. ✓ mos. ✓ ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No Date of ✓

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Examination

(Signed)

Henry C. O'Neil, M. D.

Oct 14 1922 (Address) 1203 N. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Goodlaw

Oct. 16 1922

20 UNDERTAKER

ADDRESS

J. B. Cook

1003 N. Balto

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1526 Mount ST., 15 WARD)2-FULL NAME John Thomas Garnett(a) RESIDENCE NO. 1526 Mount ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

REGISTERED NO. 268352

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Annie Garnett6 DATE OF BIRTH (month, day, and year) unknown

7 AGE

55 Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Essex Co. Virginia

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

unknown

14

Informant (Address)

Annie Garnett 1526 Mount St.

15

OCT 15 1922ROBERT B. KRAUTER

Registrar

Mortuary Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922, to Oct 14, 1922, that I last saw him alive on Oct 12, 1922, and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver(duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Place of death

Did an operation precede death?

yes

Date of

Sept 18 1922

Was there an autopsy?

no

What test confirmed diagnosis?

Exploratory incision

(Signed)

Charles E. C. C. M. D.

, 19

(Address)

1306 N. Belmont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Mt. AuburnOct 16 1922

20 UNDERTAKER

James H. Quinn

ADDRESS

1313

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.REGISTRATION NO. 268353
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1312 Park Avenue

2-FULL NAME Henrietta Cromwell Congdon

(a) RESIDENCE. No. 1312 Park Avenue
(Usual place of abode)
Length of residence in city or town where death occurred 77 yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX
Female4 COLOR OR RACE
White5 Single, Married, Widowed,
or Divorced (write the word)
Widow5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Samuel H Congdon

6 DATE OF BIRTH (month, day, and year) April 2 1845
Years Months Days7 AGE
77

6

12

If LESS than
1 day, hrs.
or min.8 OCCUPATION OF DECEASED
(a) Trade, profession or
particular kind of work

None

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore City
Maryland

10 NAME OF FATHER

Richard Cromwell
A.A.Co.11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Elizabeth Hammond
Howard Co.13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Maryland

14 Informant
(Address)Gilbert Congdon (Son)
New York City

15 Filed

OCT 16 1922

ROBERT R. MAULDER
Baltimore City Clerk

ST. 11 WARD

ST. WARD.
(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 14 1922

17 I HEREBY CERTIFY, That attended deceased from
April 7, 1922, to Oct 14, 1922.

that I last saw her alive on Oct 14, 1922, 6 P.M.

and that death occurred, on the date stated above, at
The CAUSE OF DEATH* was as follows:

Carcinoma Stomach -

CONTRIBUTORY (duration) 1 yrs. mos. ds.
(Secondary) General metastases.18 Where was disease contracted
if not at place of death?

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. H. H. H.

19 (Address) 1327 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR REMOVAL
Loudon Park CemeteryDATE OF BURIAL
Oct. 16 22

20 UNDERTAKER

Stewart & Mower Co

108 W. North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D68354
1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1206 Belmont Ave.

2-FULL NAME

James H. Booye

(a) RESIDENCE. No. 1206 Belmont Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

REGISTERED NO. D68354

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma R. Booye

6 DATE OF BIRTH (month, day, and year)

Mar 23 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

Walbert

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Jas W. Booye

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary E. Delcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Emma R. Booye 1206 Belmont Ave

15

Filed OCT 16 1922

ROBERT H. KROUTER

Burial Permit 6701

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1922

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to Oct 14, 1922, that I last saw him alive on Oct 11, 1922.

and that death occurred, on the date stated above, at 10 9. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal & Microscope

(Signed) Joseph F. Keating M. D.

19 (Address) 1800 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Green Mount Oct 16 1922

20 UNDERTAKER

ADDRESS

H. C. Windyfeld 914 Green Mount Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

73 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

OCT 15 1922

OCT 16 1922

ROBERT H. KRAUTER

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, that I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at 1:50 p.m.

The CAUSE OF DEATH* was as follows:

Gangrened foot

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1924

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Exact statement of OCCUPA-
tion should be carefully supplied. State should be carefully supplied. State should be carefully supplied.
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.
TION is very important.

Spec. 6-9-19-H. P. Co. 1900 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

REGISTERED

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 S. Patomac ST.: 1 WARD)

2-FULL NAME George Mason Murphy

(a) RESIDENCE. NO. 724 S. Patomac ST.: 1 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Anna M. Murphy

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1847

7 AGE

75

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

OCT 18 1922

Burial Permit Work

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 13 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1922, to Oct 13, 1922. that I last saw him alive on Oct 10th, 1922. and that death occurred, on the date stated above, at 6¹⁵ P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Harvey H. Witzke

15311 Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Grindall

ST.: 24th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph Kenneth Silk

(a) RESIDENCE. No. 1019 Light

ST.: 24th WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

1 yrs. 2 mos. 26 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 17, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

2

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Matthew Thomas Silk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Md.

12 MAIDEN NAME OF MOTHER

Mary Eliz. McKenney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore, Md.

14

Informant (Address)

Mrs. Matthew Silk, 1019 Light St.

15

Filed

OCT 16 1922

ROBERT H. KRAUTER, Registrar

Bartholomew

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 15, 1922

17

I HEREBY CERTIFY, That I attended deceased from October 14, 1922, to October 15, 1922,

that I last saw him alive on October 15, 1922,

and that death occurred, on the date stated above, at 6:55 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 0 yrs. 0 mos. 3 ds. over

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

1019 Light St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

19 (Address) 1243 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Cathedral City

Oct. 17 1922

20 UNDERTAKER

ADDRESS

John A. Moran 3000 E. Baltimore St.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 5 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Primary

Exact statement of OCCUPA-
tion should be carefully supplied. AGE must be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *853 24th Henry*)ST. *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John Riggs*(a) RESIDENCE NO. *853 24th Henry*

ST. _____ WARD _____

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *10/13/24*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) *Baltimore* (State or country)10 NAME OF FATHER *Cornelius I. Riggs*11 BIRTHPLACE OF FATHER (city or town) *Pa* (State or country)12 MAIDEN NAME OF MOTHER *Stella Buchholz*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)14 Informant *Cornelius Riggs*(Address) *853 24th Henry*15 Filed *OCT 15 1922* ROBERT R. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/17* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from

10/13 19*22* to *10/17* 19*22*, that I last saw him alive on *10/14/22*, 19and that death occurred, on the date stated above, at *6 A.* m.

The CAUSE OF DEATH* was as follows:

Probably Lung(duration) *several* yrs. mos. ds.CONTRIBUTORY *Arteriosclerosis* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? *No* Date of _____Was there an autopsy? *No*What test confirmed diagnosis? *Marked Scaly feet & hands*(Signed) *Bernard J. King* M. D.*10/17* 19*22* (Address) *910 W. Lombard*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*St Marys Hospital*20 UNDERTAKER *Wm. Cook*

DATE OF BURIAL

OCT 16 1922

ADDRESS

502 E. 11th St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.:

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Harry W. Williams

6 DATE OF BIRTH (month, day, and year)

March 9 1881

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

7

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Luther S. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Lauram Bolton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Harry W. Williams

15

Filed

19

OCT 15 1922

ROBERT H. [unclear] Registrar

Baltimore City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/15/22 19

17

I HEREBY CERTIFY, That I attended deceased from

Aug 1922, to Oct 15 1922

that I last saw her alive on Oct 14 1922

and that death occurred, on the date stated above, at 10:00 a.m.

The CAUSE OF DEATH* was as follows:

Bright disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

, 19 (Address)

709 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore City

Oct 17 1922

20 UNDERTAKER

ADDRESS

William [unclear] 502 E. North Ave

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Breast

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)2-FULL NAME John P. Oberlander

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 3810 Fernwood Ave. ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of _____ WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18597 AGE Years Months Days
63 -- -- If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland10 NAME OF FATHER Henry Oberlander11 BIRTHPLACE OF FATHER (city or town) Baltimore,
(State or country) Maryland12 MAIDEN NAME OF MOTHER Katherine Thus13 BIRTHPLACE OF MOTHER (city or town) Bavaria
(State or country)14 Informant Hospital Records,
(Address) Municipal Hospital.15 Filed OCT 16 1922 ROBERT H. MAULIK
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 19 2217 I HEREBY CERTIFY, That I attended deceased from August 28, 19 22, to October 15, 19 22.
that I last saw him live on October 15, 19 22.
and that death occurred, on the date stated above, at 12 Noon m.
The CAUSE OF DEATH* was as follows:Senility; Osteoporosis
(duration) 10 yrs. mos. ds.CONTRIBUTORY Chronic arthritis
(Secondary) Suppurative (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles H. Smith M. D.10/15/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Oaklawn, Oct. 18, 19 2220 UNDERTAKER Wm Cook, 507 E. North ADDRESS que

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.

1321 Hillman

ST.,

9th WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Rose A. Bannon

(a) RESIDENCE NO.

1321 Hillman

ST.,

9th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 20, 1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

31

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Francis Bannon

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Susan Riley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant (Address)

Frank Bannon 1321 Hillman St.

15

OCT 16 1922

ROBERT H. MAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

October 14, 1922

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1920 to October 14, 1922.

that I last saw her alive on

October 14, 1922

and that death occurred, on the date stated above, at

8:45 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma. over

CONTRIBUTORY (Secondary) (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

yes Date of 1920

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) Howard E. Woodruff M. D.

10/15/1922 (Address)

530 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Cathedral Ave.

DATE OF BURIAL

Oct 16 1922

20 UNDERTAKER

Margaret S. Flynn

ADDRESS

1422 Highland

ation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

068362 HEALTH DEPARTMENT—CITY OF BALTIMORE 068362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1913 Hollins

St. 20

Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1913 Hollins

St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

male

4-COLOR OR RACE,

white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH,

May

15

1896

(Month)

(Day)

(Year)

7-AGE,

76

yrs.

mos.

ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, artist

(b) General nature of industry, business, or establishment in which employed (or employer), self

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

Wm Stowell

11-BIRTHPLACE OF FATHER, (State or Country),

Balt.

12-MAIDEN NAME OF MOTHER,

Ellen Brown

13-BIRTHPLACE OF MOTHER, (State or Country),

Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

William Stowell

(Address)

1913 Hollins st.

15-

Filed

OCT 16 1922

192

ROBERT R. KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct

15

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Cytoplasia

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Lacerated Scalp

(Signed) J. Fall

(Duration) yrs. mos. ds.

Oct 16, 1922 (Address) 700 E. Charles

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore Cemetery

Oct. 17, 1922

20-UNDERTAKER,

ADDRESS

George J. Ruth 1235 Hayford av.

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *1706 Federal* ST., *0* WARD)

2-FULL NAME

(a) RESIDENCE NO. 1906 E Federal ST., _____ WARD _____
 (Usual place of abode)

(a) RESIDENCE NO. 1706 Central ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>M</i>	4 COLOR OR RACE <i>W</i>	5 Single, Married, Widowed, or Divorced, (write the word) <i>Widow</i>
-------------------	-----------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *G. T.*

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	74	3	27	

• OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) **Name of employer**

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Informant
(Address)

15
Filed _____ 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 14 1922

17 I HEREBY CERTIFY, That I attended deceased from
Dub 1914, to *Oct 15* 19*28*.

that I last saw him alive on Oct 15, 1927

and that death occurred, on the date stated above, at 8:20 a.m.

The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH was as follows:
 Chronic Valvular Disease of
 Heart

(duration) 8 yrs. 10 mos. ds.

CONTRIBUTORY
(Secondary)

(Secondary) (duration) 1 yrs. 11 mos. 1 d

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Sanderson, M.D.
(Address) 1714 N. Euclid St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

MOVAL
Oak Lawn Cemetery

20 UNDER TAKER

20 UNDER TAKER
John McElrich

DATE OF BURIAL

ADDRESS

7007622-

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S. Carey

2-FULL NAME Joseph Gordon Stockill

(a) RESIDENCE. NO. 105 S. Carey

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 2

mos. 13

ds.

How long in U. S., if of foreign birth?

REGISTERED N

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 18 WARD

ST. WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Aug 7-22

6 DATE OF BIRTH (month, day, and year)

Aug 7-22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

✓

2

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Maryland

10 NAME OF FATHER

Henry B. Stockill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Mary E. Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

Maryland

PARENTS

14 Informant (Address)

Henry B. Stockill 105 S. Carey St.

15

Filed

OCT 16 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 - 1922

17 HEREBY CERTIFY, That I attended deceased from Oct 13, 1922, to Oct 15, 1922,

that I last saw him alive on Oct 15, 1922, at 7 P. M.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry Crocker, M. D.

Oct 15 1922 (Address) 1203 St. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St Peter's

DATE OF BURIAL

Oct 18 1922

20 UNDERTAKER

John J. Fields 1200 W. Lombard

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks. **HEALTH DEPARTMENT—CITY OF BALTIMORE** **DL 68365**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Morrow Hospital*
CITY OF BALTIMORE: (No. *1122 N. Mount* ST. *6* WARD)
2-FULL NAME *George M. Paulsackel*
(a) RESIDENCE NO. *2215 E. Fairmount Ave.* ST. *6* WARD
(Usual place of abode)
Length of residence in city or town where death occurred *59* yrs. *2* mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*
5a If married, widowed, or divorced
HUSBAND of *Catharine Paulsackel*
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 6 1863*
7 AGE Years *59* Months *2* Days *8* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Mail carrier*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14

Informant *Catharine Paulsackel*
(Address) *2215 E. Fairmount Ave.*

15

Filed *Robert F. Harrison*,
19 *1922*

Registrar

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) *10-14 1922*

17 I HEREBY CERTIFY, That I attended deceased from *9-15-1922* to *10-14-1922*,
that I last saw him alive on *10-14-1922*,
and that death occurred, on the date stated above, at *930* a.m.
The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
over

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *yes*

What test confirmed diagnosis?

(Signed) *Howard J. Tobey* M.D.
, 19 (Address) *1325 S. Charles St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St. Mathew's Cem Oct 18 1922
Louis Heermann *325 Broad*
Way

dl. 68366 HEALTH DEPARTMENT—CITY OF BALTIMORE 10. 68366 CERTIFICATE OF DEATH. 155

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital*)

ST.:

WARD) *6*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Master William Wasselhoff

(a) RESIDENCE

No. *1914 E. Fannount ave.*

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 1909

7 AGE

Years

Months

Days

If LESS than 1 day... hrs. or min.

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School-Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md.

10 NAME OF FATHER

Wm. Wasselhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Isella Reskotten

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

J. Lewis & Sons, 1429 E. Baltimore St.

15

Filed

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

*10/16*19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

*10/10*19 *22*

to

*10/16*19 *22*that I last saw him alive on *Oct 16/*and that death occurred, on the date stated above, at *1:15 P.m.*

The CAUSE OF DEATH* was as follows:

Septicemia (Staphylococcus aureus)

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds. *6**Acute Osteomyelitis of left tibia*

(duration)

yrs.

mos.

ds. *8*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *10/10/22; 10/12/22*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

10/16 19 22

Address)

Louis Ochs M.D. The Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebrew Burials**10-16*19 *22*

20 UNDERTAKER

*Jack Lewis**1429 E. Baltimore St.*

1161922

Burial Permit 61612

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Arterio Sclerosis

al. 68367 HEALTH DEPARTMENT—CITY OF BALTIMORE *al. 68367*

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1527* *Baldwin*)ST.: *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph Wesley Evans

(a) RESIDENCE. NO.

*1527 Baldwin*ST.: *13* WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

Male

4-COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

*October 7, 1922, to October 14, 1922.*that I last saw him alive on *October 14, 1922.*and that death occurred, on the date stated above, at *2.30 A.M.*

The CAUSE OF DEATH* was as follows:

Ileo Cholelitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

dl. 68368 HEALTH DEPARTMENT—CITY OF BALTIMORE dl. 68368

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3701 Falls Road ST. 13 WARD)

2-FULL NAME

Elias Washington Frost

(a) RESIDENCE NO.

3701 Falls Road ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie B Frost

6 DATE OF BIRTH (month, day, and year)

March 14-1854

7 AGE

68

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Howard Co. Maryland

10 NAME OF FATHER

Elias W Frost

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Howard Co. Maryland

12 MAIDEN NAME OF MOTHER

Sophia Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Howard Co. Maryland

14

Informant (Address)

Mrs. Annie B Frost 3701 Falls Road

15

Filed

Robert P. Harbeck,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 9, 1922 to Oct. 14, 1922.

that I last saw him alive on Oct 14, 1922.

and that death occurred, on the date stated above, at 11:15 P.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORS (Secondary)

(duration)

yrs.

mos.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

No.

Did an operation precede death?

No.

Date of

Was there an autopsy?

No.

What test confirmed diagnosis?

Autopsy - E.P.C. - Blood

(Signed)

E. E. Kelly, M. D.

14, 1922

(Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Olivet

DATE OF BURIAL

Oct. 17, 1922

20 UNDERTAKER

Horace H. Burgee 363 Falls Rd

ation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

16 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 13 WARD)

2-FULL NAME William Haskins

(a) RESIDENCE NO. 2426 McCullough St ST. 13 WARD 13
(Usual place of abode)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1893
7 AGE Years Months Days If LESS than 1 day, hrs or min.
29 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Richmond,
(State or country) Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 19 22

17 I HEREBY CERTIFY, That I attended deceased from August 8 19 22 to October 15 19 22 that I last saw him alive on October 15 19 22 and that death occurred, on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:

Syphilis

CONTRIBUTORY (duration) 10 yrs. mos. ds.
(Secondary) General paralysis
the disease (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Wor. C. S. Fluoride
(Signed) Plyde M. Neil M. D.

10/15/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Richmond Va.

DATE OF BURIAL

20 UNDERTAKER

George J. Smith

ADDRESS

1000 N. Fayette

Exact statement of cause of death should be supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

ST 16 1922

Burial Permit: 01234

D. 68370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68370

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No

1436 Cresskill St

ST.: 9

WARD)

2-FULL NAME

Anna Louise Forney

(a) RESIDENCE

No 1436 Cresskill St

ST.: 9

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

White

4 COLOR OR RACE

Widowed

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joshua Forney

6 DATE OF BIRTH

7 AGE

78

Months

7

Days

10

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Fray, Md.

10 NAME OF FATHER

Peter W. Gibbons

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Fray, Md.

12 MAIDEN NAME OF MOTHER

Eliza A. Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ellicott City, Md.

14 Informant

(Address)

Emily Upshur 1734 1st Ave St

15

OCT 16 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, year) October 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1922, to Oct 15 1922.

that I last saw her alive on Oct 15 1922, and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows: cerebral apoplexy.

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. H. G. M. D.

(Address) 401 E 35th St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

Oct 17 1922

20 UNDERTAKER

Henry W. Jenkins, Local 1000

D. 68371 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68371

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Mercy Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

ST.

WARD)

2-FULL NAME

Charles Pearce

(a) RESIDENCE NO.

Irish City Steamship

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

26

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

25

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

M. Brown

6 DATE OF BIRTH (month, day, and year)

April 27 1864

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

58 5 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Greaser

(b) General nature of industry, business, or establishment in which employed (or employer)

Steamship

(c) Name of employer

Maurice B. Carter Co.

9 BIRTHPLACE (city or town)
(State or country)

England

10 NAME OF FATHER

Robert Pearce

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

England

12 MAIDEN NAME OF MOTHER

Elizabeth

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

England

14

Informant
(Address)

Recon. Mercy Hosp

15

Filed

Robert F. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 15 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 21, 1922, to Oct. 15, 1922.

that I last saw him alive on Oct. 15, 1922.

and that death occurred, on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Les.

Cardiac failure

Hemiplegia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Pulmonary Oedema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. J. Resagno, M. D.

; 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Cedar Hill Cem Oct 17 1922

John B. Cook 1003 E. Baltimore

20.68372 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68372

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.)

2-FULL NAME

(Residence in Baltimore: No.)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER, (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. KAYLOR,

16-

Marial P. KAYLOR

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute alcoholism
(his history of white kind of alcohol)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.
(Signed) J. J. Hennessy, M. D.
(Coroner)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

London Pub Co

Oct. 17, 1922

20-UNDERTAKER

ADDRESS

for foerden son 2178 Bay

22.68373

HEALTH DEPARTMENT—CITY OF BALTIMORE

22.68373

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2216 Wilkens Ave St. 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Louis E. McGinnis

St.; yrs..... mos..... ds.)

(Residence in Baltimore: No. 2214 Wilkens Ave

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male 4-COLOR OR RACE white 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH June 27 1872 (Month) (Day) (Year)

7-AGE 60 yrs. 3 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Candy Maker (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country) Galts md

10-NAME OF FATHER James McGinnis

11-BIRTHPLACE OF FATHER Galts md (State or Country)

12-MAIDEN NAME OF MOTHER Mary Hayes

13-BIRTHPLACE OF MOTHER Ireland (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ralph A. McGinnis (Address) 2216 Wilkens Ave

15- Robert P. Harralson, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct 14 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Asphyxiation by suffocation

CONTRIBUTORY (Secondary) Suicidal Insanity (Duration) yrs. 9 mos. 1 ds.

(Signed) James M. Pennington M. D. (Coroner.) 7008 Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). In the At place of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL Oct 17 1922

20-UNDERTAKER Wm Corke ADDRESS 474 Hill

ST 61922

Mersmann ✓
10.68374 HEALTH DEPARTMENT—CITY OF BALTIMORE **10.68374**

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *1338 N Washington* ST., *8* WARD)

2. FULL NAME

(a) RESIDENCE No. *1338 N Washington* ST., *8* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *1 1/2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, with ~~husband~~ divorced (or) WIFE of *Frank Mersmann*6 DATE OF BIRTH (month, day, and year) *Jun 6 - 1865*7 AGE Years *58* Months *8* Days *9* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Balti*

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Leahy*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Philadelphia*12 MAIDEN NAME OF MOTHER *Coolidge*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balti*14 Informant *Frank Mersmann* (Address) *1338 N Washington*15 Filed *Robert P. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 15 1922*17 HEREBY CERTIFY, That I attended deceased from *Jan 10 1922* to *Oct 15 1922* that I last saw him alive on *Oct 15 1922*and that death occurred, on the date stated above, at *10 30 P* m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Edward J. Cook* M. D. Address *413 N Washington*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

419 N. Robinson

ST.

WARD)

2-FULL NAME

Grace Elizabeth Drebing

(a) RESIDENCE. NO.

419 N. Robinson

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

35 yrs. 4 mos. 3 ds.

How long in U. S. if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 12-1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35

4

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John A. Kratz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto.

12 MAIDEN NAME OF MOTHER

Mary E. Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant (Address)

Louis E. Drebing 419 N. Robinson st

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 — 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 12th, 1922, to Oct. 15th, 1922,that I last saw her alive on Oct. 15th, 1922,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocard. Li.

Mistake Regurg. Valvular

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Myocardial Failure

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Phil. L. Artigiani, M. D.

, 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Soudon Park Cemetery Oct 18th 1922

20 UNDERTAKER

Geo M. Fink & Son 811 N. Wolfe

161322

Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

907 N. Mueberry St.

ST.

WARD) 18

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret P. Laughlin

(a) RESIDENCE. NO.

907 N. Mueberry St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of

William Laughlin

6 DATE OF BIRTH (month, day, and year)

Sept 19th 1844

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md

10 NAME OF FATHER

John Dippel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

Mrs. Jennie L. Lavelle

1011 N. Mueberry St. Howard Park

15

Filed

OCT 17 1922

ROBERT K. [Signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 16th 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1st, 1922, to Oct 16, 1922, that I last saw him alive on Oct 16, 1922,

and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) 1 yrs. 2 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt. J. Murray, M. D.

Address 1510 N. Fremont Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery

20 UNDERTAKER

Wilbur W. Shivers

DATE OF BURIAL

Oct 18th 1922

ADDRESS

1018 Edmondson Ave.

268377

HEALTH DEPARTMENT—CITY OF BALTIMORE

268377

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 N. Fulton Ave. St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William Alfred Chalk

(Residence in Baltimore: No. 1712 N. Fulton Ave., St. 15, yrs. 78, 2 mos. 25 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH, August 19, 1884 (Month) (Day) (Year)

7-AGE, 78 yrs. 2 mos. 25 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, retired (b) General nature of industry, business, or establishment in which employed, carpenter

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Lewis Chalk

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Loretta Davis

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. A. Chalk

(Address) 1712 N. Fulton Ave.

15- OCT 17 1922 ROBERT R. MAUTER, Registrar. Filed 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 15, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) No history.

(Signed) J. S. Humphrey, M. D. (Coroner.)

Oct. 16, 1922 (Address) 787 2 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, London Park Oct 18 1922

20-UNDERTAKER, ADDRESS, W. W. Shriver 1018 Edmondson Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Hanover St.)ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances M. Matusky(a) RESIDENCE. NO. 1322 Hanover St.
(Usual place of abode)ST. 23 WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female. White.Single.5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) March 4, 1922.

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.7 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Md.10 NAME OF FATHER Joseph F. Matusky.11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.12 MAIDEN NAME OF MOTHER Mamie M. Schmincho.13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.14 Informant Joseph F. Matusky.
(Address) 1622 Hanover St.

15 Filed

19

Oct 17 1922RUMRI R. MAUL

Registrar

Basal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-15 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 14, 1922, to Oct 15, 1922that I last saw her alive on Oct 15, 1922and that death occurred, on the date stated above, at 6:11 m.

The CAUSE OF DEATH* was as follows:

Coronary artery disease
to heart failure

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Evans M. D.1914 (Address) 1000 N. 1st St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery.October 17,

20 UNDERTAKER

ADDRESS 22.Mrs. J. E. Evans & Sons 1428 S. Charl-
es St.

tion should be carefully supplied. 2000 copies of this form are supplied to the health department. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

D 68378

80

068379 HEALTH DEPARTMENT—CITY OF BALTIMORE 068379

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital, 23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie E. Swan.

39 -- 2 ---- 23.

(Residence in Baltimore: No. 162 W. Cross St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female. 4-COLOR OR RACE. White. 5-Single, Married, Widowed, or Divorced. Married.

6-DATE OF BIRTH. July 28, 1883. (Month) (Day) (Year)

7-AGE. 39 yrs. 2 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Housework. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore Md.

10-NAME OF FATHER. William Goodman.

11-BIRTHPLACE OF FATHER. (State or Country). Queen Anne Co. Md.

12-MAIDEN NAME OF MOTHER. Annie Myers.

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Carrie Seymour. (sister).

(Address). 162 W. Cross St.

15-

Filed. 1922 ROBERT R. KRAUTER Registrar.

OCT 17 1922

Badal Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. October 15, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry. (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull. Accidental fall down the cellar steps on cement floor.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signature) Otto M. Reinhardt (Coroner) Oct. 16, 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds. Accident

Where was disease contracted, if not at place of death? at 1622 Webster St. Oct. 14, 1922. 6.30 p.m.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. Cedar Hill Oct 15, 1922

20-UNDERTAKER.

ADDRESS

Mrs. J. E. Evans 1428 E. Charles St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *328 N. Pine* ST. *4* WARD)2-FULL NAME *Wm Jordan*(a) RESIDENCE NO. *328 N. Pine* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred *35* yrs. mos. ds.

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*4 COLOR OR RACE *Colored*5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *none*6 DATE OF BIRTH (month, day, and year) *1879*

7 AGE

Years *43*

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Cook*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Federick Md*10 NAME OF FATHER *George Jordan*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Leonia Stewart*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14

Informant (Address) *Louise Jordan 228 N. Pine St*

15

Filed

OCT 17 1922

ROBERT H. MAULTY Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 14 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 1*, 1922, to *Oct 14*, 1922, that I last saw him alive on *Oct 14*, 1922,and that death occurred, on the date stated above, at *825 1/2* m.

The CAUSE OF DEATH* was as follows:

Frunk's Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *228 N. Pine St*Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Charcot's L. Symptom*(Signed) *W. H. H. H. H.* M. D.Address *7125 Pampa Road*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

NOV

UNDERTAKER

DATE OF BURIAL

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

268381

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Univ. Hospital* ST.: *17* WARD)

2-FULL NAME

(a) RESIDENCE, NO. *Rita Wilson*

(Usual place of abode)

Length of residence in city or town where death occurred *608 Dolphin* ST.: *17* WARD.*12* yrs. *12* mos. *12* ds.

(If nonresident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *April 5-1910*

7 AGE

12 yrs. *6* mos. *9* ds.

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Levie Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Lena Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mass.

14 Informant (Address)

Hospital Records

15 Filed

19

OCT 17 1922

ROBERT R. HALL

Burial Permit Clerk

16 DATE OF DEATH (month, day, and year) *October 14 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Sept. 27, 1922, to Oct. 14, 1922,*that I last saw him alive on *October 14, 1922,*and that death occurred, on the date stated above, at *8:25 P.M.*

The CAUSE OF DEATH* was as follows:

Acute Valvular endocarditis

CONTRIBUTORY (Secondary)

not known (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? *Home*Did an operation precede death? *no* Date ofWas there an autopsy? *yes*What test confirmed diagnosis? *Lab. reports, autopsy*(Signed) *E. C. Halley*, M. D.(Address) *Univ. Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Ambrose Cem

20 UNDERTAKER

*James H. Hensley**M. B. Hensley**M. B. Hensley*

Exact statement of OCCUPATION should be carefully supplied. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Jillie Bindeman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Agnes Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 21 WARD)

2-FULL NAME

Jillie Bindeman

(a) RESIDENCE NO.

709 McHenry

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

Wh

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept-10-1900

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

22

1

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Factory Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Chas. Bindeman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Elizabeth Roll

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mr. Chas. Bindeman 709 McHenry St.

15

OCT 17 1922

ROBERT R. KRANTZ Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-16-1922

17

I HEREBY CERTIFY, That I attended deceased from

10-15-1922, to 10-16-1922

that I last saw her alive on 10-16-22, 1922

and that death occurred, on the date stated above, at 1:40 PM.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction of two days duration

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 10-15-22

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) J. C. Palmer, M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

Oct 17 1922

20 UNDERTAKER

ADDRESS

John J. Cowan 901 Hollister

268383

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1005 S. Charles Street. St. 23 Ward)

Registered No. 268383

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Daniel Adenberg.

(Residence in Baltimore: No. 1005 S. Charles St. St.; yrs. 9 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male. 4-COLOR OR RACE White. 5-Single Married. Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH. January 30, 1892. (Month) (Day) (Year)

7-AGE, 30 yrs. 8 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Dry goods (b) General nature of industry, business, or establishment in which employed (or employer) merchant.

9-BIRTHPLACE, (State or Country), Russia.

PARENTS. 10-NAME OF FATHER, David Adenberg. 11-BIRTHPLACE OF FATHER, (State or Country), Russia. 12-MAIDEN NAME OF MOTHER, Yetta Swanitz. 13-BIRTHPLACE OF MOTHER, (State or Country), Russia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Adenberg. (father).

(Address) 1914 E. Fairmount Ave

15-

Filed

OCT 17 1922

1922

ROBERT R. MAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 16, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Reinhardt M. D. (Coroner.)

Oct. 16, 1922 (Address) 1917 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

10-17, 1922

20-UNDERTAKER, ADDRESS

Jaco Lewis, 1430 E. Balto.

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. S. Baltimore Gen. Hospi. ST. 25 WARD)

2-FULL NAME

John Kupen

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

1106 Pennington Ave

ST.

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 32 Years — Months — Days

If LESS than 1 day, hrs.

or min.

Noknow

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Noknow

9 BIRTHPLACE (city or town) (State or country)

Lithuania

10 NAME OF FATHER

Jekup Kupen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Lithuania

12 MAIDEN NAME OF MOTHER

Nok.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Lithuania

14

Informant (Address)

E. Kupen 1106 Peninkton Ave

15

File

171922

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

October 14 1922 to October 16 1922

that I last saw him alive on October 16 1922

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of October 16/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

John A. Adams M. D.

19

(Address) South Baltimore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Cross Cem. A.R.

Oct. 19, 1922

20 UNDERTAKER

John Grebliauckas 425 S. Paca S

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 Locust)ST.; 75 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 102 Locust)

St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 22, 1922
(Month) (Day) (Year)

7-AGE, yrs. 7 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

OCT 17 1922

Filed.....

191.....

ROBERT R. KAUFER

Baltimore, Md.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 13 1922, to Oct 16 1922, that I saw him alive on Oct 15 1922, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage

CONTRIBUTORY (Secondary)

(Signed) Dr. H. H. H. H. H. M. D.

1016, 1922 (Address) 1340 St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

068386 HEALTH DEPARTMENT—CITY OF BALTIMORE 068386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1424 Mulligan St., 5 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1424 Mulligan St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

Black

5-~~Single~~,
Married,
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH.

(Month) (Day) (Year) 1881

7-AGE.

41

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular

kind of work

(b) General nature of industry,

business, or establishment in

which employed (or employee).

Hookster

9-BIRTHPLACE.

(State or Country).

Virginia

10-NAME OF FATHER.

Stephen Brown

11-BIRTHPLACE OF FATHER.

(State or Country).

Virginia

12-MAIDEN NAME OF MOTHER.

Mary

13-BIRTHPLACE OF MOTHER.

(State or Country).

Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Mary Brown

(Address).

1424 Mulligan St.

15-

Filed

OCT 17 1922

ROBERT R. KAUTER

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Oct

15

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

Patent

Natural Cause

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

Oct 16, 1922

(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

adbury cemetery

OCT 17

20-UNDERTAKER.

ADDRESS

Edward Brown

Orlando St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

704 W. North Ave.

ST. 13 WARD)

2-FULL NAME

Elizabeth F. McGreevy

(a) RESIDENCE. NO.

704 W. North Ave.

ST. WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

* *

6 DATE OF BIRTH (month, day, and year)

7 AGE

50

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

O'Neil's Store

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

James H. McGreevy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Augusta Carlow

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ohio

14

Informant (Address)

Miss Fannie McGreevy

704 W. North Ave.

15

OCT 17 1922

W. H. MAUTEN

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15. 1922

17 I HEREBY CERTIFY, That I attended deceased from

June 1, 1922, to Oct 15, 1922, that I last saw him alive on Oct 15, 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of =

Was there an autopsy? No

What test confirmed diagnosis? Cough, expectoration, emaciation

(Signed)

Charles O. Dwyer M. D.

Oct 17, 1922 (Address)

5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

Oct. 18-22

20 UNDERTAKER

Chas. F. Evans & Son

118 W.

Mt. Royal

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2313 Division ST. 14 WARD)2-FULL NAME Frank Thomas Dorsey

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 2313 Division ST. 14 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word)5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant6 DATE OF BIRTH (month, day, and year) Dec 28, 19217 AGE Years 9 Months 18 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 2313 Division St. Baltimore Md. (State or country)10 NAME OF FATHER Howard E. Dorsey11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Beatrice Dorsey13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant Mathe Emory (Address) 2313 Division St.15 Filed OCT 17 1922 ROBERT R. MAULIER Registrar Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 192217 I HEREBY CERTIFY, That I attended deceased from Oct 15 1922 to Oct 16 1922 that I last saw him alive on Oct 16 1922and that death occurred, on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Rickets(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical(Signed) William H. Wright M. D.(Address) 1209 Pressman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

mt Zion Am.

DATE OF BURIAL

Oct 18 1922

20 UNDERTAKER

Joseph A. Farrell

ADDRESS

2319 Division St

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 E. Chase)ST. 10 WARD

2-FULL NAME

(a) RESIDENCE NO. 932 E. Chase

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds.ST. 10 WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? 43 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married6a If married, widowed, or divorced HUSBAND or WIFE of Margaret E. Farrelly6 DATE OF BIRTH (month, day, and year) Not known

7 AGE

about 63

Years

Months

Days

If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Saloon keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Michael Farrelly

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Elizabeth Hand

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14 Informant (Address)

Mrs Margaret E. Farrelly932 E. Chase

15

Filed

Bureau of Health

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 16 192217 I HEREBY CERTIFY, That I attended deceased from Sept 25, 1922, to Oct 16, 1922, that I last saw him alive on Oct 15, 1922, and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia over

CONTRIBUTORY (Secondary)

(duration)

yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed)

James W. Farrelly, M. D.1016. 1922 Address200 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

DATE OF BURIAL

Oct 19 1922

20 UNDERTAKER

Henry Horch Sr

ADDRESS

1301 E. Egan St

N. B.—WRITE PLAINLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

ation should be carefully supplied. Are around the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

68390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114-68390

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mt Hope Retriah* ST. *28* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret A. Beutz

(a) RESIDENCE. NO.

917 Mulberry St - Balto Md.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *2* mos. *2* at *Mt Hope* How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*
5a If married, widowed, or divorced HUSBAND of *Mr Beutz* (or) WIFE of
6 DATE OF BIRTH (month, day, and year) *Aug 25 - 187*
7 AGE Years *50* Months *0* Days *0* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *None - Wf. of meat cutter*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) *Baltimore Md.* (State or country)

10 NAME OF FATHER *Henry Mahner*
11 BIRTHPLACE OF FATHER (city or town) *Balto Md.* (State or country)
12 MAIDEN NAME OF MOTHER *+ O'Neill*
13 BIRTHPLACE OF MOTHER (city or town) *Baltimore Md.* (State or country)

14 Informant *Records of Mt Hope Retriah* (Address) *Mt Hope Md.*

15 *OCT 17 1922* *ROBERT R. KRAUTER*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 15* 1922
17 I HEREBY CERTIFY, That I attended deceased from *Aug 8*, 1922, to *Oct 15*, 1922, that I last saw her alive on *Oct 15*, 1922, and that death occurred, on the date stated above, at *11.30 P.* m. The CAUSE OF DEATH* was as follows: *Acute Gastro-Enteritis*

abt (duration) *0* yrs. *0* mos. *14* ds.
CONTRIBUTORY *Delusional Mania* (Secondary) *abt* (duration) *0* yrs. *7* mos. *0* ds.

18 Where was disease contracted *Baltimore Md.* if not at place of death?
Did an operation precede death? *No* Date of
Was there an autopsy? *No*

What test confirmed diagnosis?
(Signed) *Frank J. Flannery*, M. D. *Oct 16* 1922 (Address) *Mt Hope Retriah*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Calvary Lawn Cemetery* DATE OF BURIAL *Oct 19* 1922

20 UNDERTAKER *H. B. Ramming & Son* ADDRESS *517 N. Schroeder St*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 N. Gay ST., 7 WARD)

2-FULL NAME

Anna M. Rosenthal

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
1017 N. Gay ST., 7 WARD
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant
(Address)

15

Filed

ROBERT R. BAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 192217 I HEREBY CERTIFY, That I attended deceased from Oct 15th 1922 to Oct 15th 1922that I last saw her alive on Oct 15th 1922and that death occurred, on the date stated above, at 10:45 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1977 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

068391

113 068391

Holy RedeemerJerkent JicklerOct 17 19221739Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 N. Washington ST., 7 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

Filed

19

ROBERT A. MAUTER

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 19 22

17

I HEREBY CERTIFY, That I attended deceased from
about 2 years, 19 1920, to Aug 16th, 19 22.
that I last saw him alive on Aug 15th, 19 22.and that death occurred, on the date stated above, at 5:10 A m.

The CAUSE OF DEATH* was as follows:

Valv. disease heartCONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? all(Signed) W. H. Hiley, M. D.(Address) 1239 Broadway*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

N. B.—WRITE EXACTLY AS SUPPLIED. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully checked for accuracy. Exact statement of occupation is very important. See instructions on back of certificate.

268393

HEALTH DEPARTMENT—CITY OF BALTIMORE

268393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 Archer St. 21 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Carrie Mahone

(Residence in Baltimore: No. 613 Archer St. 43 yrs. 3 mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Colored 5-Single, Married, Widowed, or Divorced, Married (Write the word.)

6-DATE OF BIRTH, 1879 (Month) (Day) (Year)

7-AGE, 43 yrs.mos.ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, House work (b) General nature of industry, business, or establishment in which employed (or employer), at home

9-BIRTHPLACE, (State or Country), Maryland

10-NAME OF FATHER, Frank West

11-BIRTHPLACE OF FATHER, (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Jda Lee

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jda Lee (Address) 613 Archer St

15-ROBERT R. KAUTER, Registrar.

Filed OCT 17 1922 1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 13, 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held on inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, find that said deceased came to her death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) sudden yrs.mos.ds.

CONTRIBUTORY (Secondary) (Duration)yrs.mos.ds.

(Signed) James W. Fenton M. D. (Coroner)

Oct 16 1922 (Address) 700 E. Charles

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death,yrs.mos.ds. In the State,yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Shipley Md Oct 17, 1922

ADDRESS, Rb Gross 1405 McElderry

N. B.—Every item of information should be carefully checked and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D68394		Gann		J 68394	
HEALTH DEPARTMENT—CITY OF BALTIMORE					
CERTIFICATE OF DEATH.					
1-PLACE OF DEATH		Registered No. C.....			
City of BALTIMORE: (No. <u>U. P. 1. In Murray</u> St. <u>21</u> Ward)		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)			
2-FULL NAME <u>Morris Gann</u>					
(Residence in Baltimore: No. <u>717 Mc Henry St.</u> St.; yrs. <u>26</u> mos. ds.)					
PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.		
3-SEX. <u>Male</u>	4-COLOR OR RACE, <u>White</u>	5-Single, Married, Widowed, or Divorced, <u>Married</u> (Write the word.)	16-DATE OF DEATH, <u>October 16,</u> 19 <u>22</u> (Month) (Day) (Year)		
6-DATE OF BIRTH, <u>1857</u> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <u>inquest</u> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <u>inquest</u> (Inquest, autopsy or inquiry.) and that said deceased came to <u>this</u> death on the day stated above.		
7-AGE, <u>67</u> yrs. mos. ds. If LESS than 1 day, hrs. or min.?			The CAUSE OF DEATH* was as follows:		
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <u>Highway Teacher</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>668</u>			<u>fracture of skull</u>		
9-BIRTHPLACE, (State or Country), <u>Russia</u>			(Duration) yrs. mos. ds. <u>16 hrs.</u>		
PARENTS.	10-NAME OF FATHER, <u>Unknown</u>		CONTRIBUTORY <u>Street car accident</u> (Secondary)		
	11-BIRTHPLACE OF FATHER, (State or Country), <u>Russia</u>		(Duration) yrs. mos. ds.		
	12-MAIDEN NAME OF MOTHER, <u>Unknown</u>		(Signed) <u>J. J. Hennessy</u> , M. D. (Coroner.)		
	13-BIRTHPLACE OF MOTHER, (State or Country), <u>Russia</u>		<u>Oct 17, 1922</u> (Address) <u>2802 Edmondway</u>		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>J. Henry</u> (Address) <u>1439 E. Balto. St.</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
15- Filed <u>OCT 17 1922</u> <u>ROBERT A. KENNEL</u> Registrar			18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?		
			Former or usual residence.....		
			19-PLACE OF BURIAL OR REMOVAL, <u>Highway Wash Road</u> DATE OF BURIAL, <u>10-18-</u> 19 <u>22</u>		
			20-UNDERTAKER, <u>Fact Lewis, 1439 E. Balto.</u> ADDRESS.....		

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Brooklyn Md.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

331 Potomac

ST., 25th WARD)

2-FULL NAME

Holfcom (Infant)

(a) RESIDENCE NO.

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 16-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

9 mos.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

331 Potomac St. Brooklyn, Ind.

10 NAME OF FATHER

Edgar A. Holfcom

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mildred R. Chromster

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Edgar A. Holfcom 331 Potomac St. Brooklyn, Ind.

15

OCT 17 1922

ROBERT R. MAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 16, 1922, to Oct. 16, 1922

that I last saw him alive on Oct. 16, 1922

and that death occurred, on the date stated above, at 12:15 p. m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chas. D. Brooke, M. D.

, 19 (Address)

Brooklyn, Ind.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery

Oct 17 1922

20 UNDERTAKER

ADDRESS

John F. Denny

75 Light St

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. PHYSICIAN'S statement should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST. 15 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

4 yrs.

X mos.

X ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Negro

Married

If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles Rayne

6 DATE OF BIRTH (month, day, and year)

Feb 5, 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

West River, Maryland Co., Md

10 NAME OF FATHER

Perry Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Mary J. Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant

(Address)

Chas Rayne, 1521 Leslie

15

Filed

19

ROBERT M. KRAUSE Registrar

OCT 17 1922

Serial Permit Blank

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-14-1922

17

I HEREBY CERTIFY, That I attended deceased from

9-10, 1922, to 10-14, 1922

that I last saw him alive on Oct. 13, 1922,

and that death occurred, on the date stated above, at 2:20 a.m.

The CAUSE OF DEATH* was as follows:

myocarditis

over

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary)

Terminal nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) John E. J. Campbell, M. D.

, 19 (Address) 1405 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

McAuburn

10/17/1922

20 UNDERTAKER

ADDRESS

Sam'l Housley, 218 N. Mount

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2604 Fair ST.) WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Jeriorski(Residence in Baltimore: No. 2604 Fair St.; 40 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married (Write the word.)6-DATE OF BIRTH, Sept 13, 1910 (Month) (Day) (Year)7-AGE, 62 yrs., 1 mos., 2 ds. If LESS than 1 day, hrs. or min.8-OCCUPATION: (a) Trade, profession, or particular kind of work. Bay Market (b) General nature of industry, business, or establishment in which employed (or employer). Wardrobe9-BIRTHPLACE, (State or Country), Poland10-NAME OF FATHER, Andrzej Jeriorski11-BIRTHPLACE OF FATHER (State or Country), Poland12-MAIDEN NAME OF MOTHER, Katy Dobra13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Jeriorski(Address) 2604 Fair St.15- OCT 17 1922 ROBERT R. MAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 15, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct 9, 1922, to Oct 15, 1922, that I saw him alive on Oct 15, 1922, and that death occurred, on the date stated above, at 5:30 p.m. The CAUSE OF DEATH* was as follows:Subacute pneumonia (Duration) 7 yrs., mos., ds.CONTRIBUTORY (Secondary) (Duration) yrs., mos., ds.(Signed) Dr. J. J. M. D. Oct 16, 1922 (Address) 222 S. Ann St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Stanislaus DATE OF BURIAL, Oct 19, 192220-UNDERTAKER, M. J. Sadowski ADDRESS, 705 S. Ann St.

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 10 WARD)2-FULL NAME Louisa Bosley(a) RESIDENCE No. 840 Coke Alley

(Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry Bosley6 DATE OF BIRTH (month, day, and year) 18907 AGE 32 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Rag Factory

(c) Name of employer

9 BIRTHPLACE (city or town) Montgomery Co., Maryland10 NAME OF FATHER Stephen Redigs11 BIRTHPLACE OF FATHER (city or town) Maryland12 MAIDEN NAME OF MOTHER Mandy Palmer13 BIRTHPLACE OF MOTHER (city or town) Maryland14 Informant Hospital Records.(Address) Municipal Hospital.15 Oct 17 1922 ROBERT H. KAUTER

Filed

Registrar

Bureau of Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 14 19 2217 I HEREBY CERTIFY, That I attended deceased from October 11, 19 22, to October 14, 19 22. that I last saw her alive on October 13, 19 22.and that death occurred, on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows:

Epidemic encephalitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Q. sp. fluid etc
(Signed) Clyde McNeil M. D.Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oct 17 19 22

20 UNDERTAKER

ADDRESS

Oversight Health

See W. H. WOODBURY

Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2714 Almada* ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. *2714 Almada* ST.,

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Oct 11, 1922, to Oct 15, 1922, that I last saw him alive on Oct 11, 1922,

and that death occurred, on the date stated above, at 4-30 A.M.

The CAUSE OF DEATH* was as follows

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis - Hypertension (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Geo. F. Taylor, M. D.

1011, 1922 (Address) 1204 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Baltimore Cemetery Oct 18, 1922

ADDRESS 1444

Gott & Turner Inc Broadway

N. B.—WRITE PLAINLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2017 E Lafayette Ave ST., 8 WARD)

2. FULL NAME

(a) RESIDENCE NO. 2017 E Lafayette ST., 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Nazel C. Donaldson6 DATE OF BIRTH (month, day, and year) June 14 18787 AGE Years 44 Months 4 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country) Balto Md12 MAIDEN NAME OF MOTHER Agnes Kington13 BIRTHPLACE OF MOTHER (State or country) Balto Md14 Informant Nazel C. Donaldson (Address) 2017 E Lafayette Ave15 Filed 171822 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 192217 I HEREBY CERTIFY, That I attended deceased from Oct 12, 1922, to Oct 16, 1922, that I last saw him alive on Oct 15, 1922, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat and Lungs.(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. M. White, Jr. 10/16, 1922 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

St Vincent Oct 19, 192220 UNDERTAKER Robt & Turner Inc ADDRESS 144 Broadway

Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

68402 HEALTH DEPARTMENT—CITY OF BALTIMORE 68402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Sexton ST. 25 WARD)

2-FULL NAME

Virginia Mae Baldwin

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

1023 Sexton

ST. 25 WARD 25

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 5 mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

female white Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 19 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Harrison M. Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Maryland

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Harrison M. Baldwin 1023 Sexton St

15

Filed

Robert P. Harrison, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 12 1922 to Oct 16 1922

that I last saw her alive on Oct 16 1922

and that death occurred, on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. J. McKieffer, M. D.

(Address) 2320 Park Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

St Marys Hampden

DATE OF BURIAL

ADDRESS

20 UNDERTAKER

Mr & Mrs N. D. Fink

Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

CT 17 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68403

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 503. S. Wolfe

ST. 2 WARD)

2. FULL NAME Sophia. Lijewski

(a) RESIDENCE NO. 503. S. Wolfe

(Usual place of abode)

Length of residence in city or town where death occurred about 10 yrs. mos. ds.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Steve. Lijewski

6 DATE OF BIRTH (month, day, and year) May 11 1899

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

23

5

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hazleton Penn. (State or country)

10 NAME OF FATHER Joseph Krusniewski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Leokadia Begier

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Teofil Krusniewski (Address) 1820 Bank Street

15 Filed R. H. P. HARRISON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1922

17 I HEREBY CERTIFY, That I attended deceased from

August 18, 1922, to October 16, 1922.

that I last saw him alive on October 15, 1922.

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) Terminal Broncho-pneumonia (duration) yrs. mos. ds. 15 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs.

(Signed) D. B. Bronushav M. D.

10-17, 1922 (Address) 3037 Ordonnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Rosary

Oct 19 1922

20 UNDERTAKER

John M. Weber 1803 Bank

OCT 17 1922

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH CARE. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

N. B.—Every item of information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

✓
D. 68404 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68404
90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

Bay View Hospital

Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Alexander Kurisch

(Residence in Baltimore: No.

1616 Shakespeare St

Oct 14
St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male
4-COLOR OR RACE, white
5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH

Unknown

7-AGE

about 37 yrs.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE, (State or Country).

Rumania

10-NAME OF FATHER,

Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

Rumania

12-MAIDEN NAME OF MOTHER,

Unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

Rumania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Anne Kurisch

(Address)

1616 Shakespeare St

15-

Robert P. HARRISON,

1922

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 15, 1922
(Month) (Day) (Year)

17-

I HEREBY CERTIFY That I took charge of the

remains described above, held an Autopsy

(Inquest, autopsy, or inquiry.)

thereon and from the evidence obtained by said

find that said deceased came to his death

topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Unconscious 24 hours prior to death

CONTRIBUTORY

(Secondary)

Shrapnel (Duration) 17 mos. ds.

(Signed) Dr. B. Harrison M. D.

Oct 17, 1922 (Address) Curtis Bay

*State the Disease Causing Death, or if Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Wab Cross German Hill

Oct 17, 1922

20-UNDERTAKER

ADDRESS

John M. Weber

1803 Bank

D. 68405 HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore, Md.

CITY OF BALTIMORE NO. 2244 Guilford Ave

ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Louise Glensky

(a) RESIDENCE NO. 2244 Guilford Ave

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Frederick Glensky

6 DATE OF BIRTH (month, day, and year) July 14 - 1843

7 AGE Years 79 Months 3 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Gottlieb Schumbacher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth L. Schumbacher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address) Mrs. Charles J. Brown 2244 Guilford Ave

15 Filed 1922 19 P. HARRISON, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 2, 1922, to Oct. 16, 1922,

that I last saw her alive on Oct. 16, 1922,

and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH was as follows:

Pneumo-purumonia

812 corner of Broadway

(duration) yrs. mos. 10 ds.

CONTRIBUTORY Injury due to fall

(Secondary) (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. Brown, M. D.

19 (Address) 2439 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Presbyterian Burial Oct 19 1922

20 UNDERTAKER ADDRESS

Wm Cook 502 E. North

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. TION is very important.

OCT 17 1922

Special Permit Clerk.

1068406

HEALTH DEPARTMENT—CITY OF BALTIMORE

1068406

CERTIFICATE OF DEATH

101-001

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1405 ST. 15 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1405 ST. 15 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 11

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 13, 1922, to Oct 16, 1922.

that I last saw her alive on Oct 16, 1922.

and that death occurred, on the date stated above, at 6:58 p.m.

The CAUSE OF DEATH* was as follows:

Subar pneumonia

(duration) no yrs. no mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Eastern Cemetery

Oct 18, 1922

20 UNDERTAKER

ADDRESS

George J. Smith

1000

PHYSICIANS should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

CT 17 1922

Filed

19

Registrar

Burial Permit 0101

CUPA-
 Exact statement of
 Cause of Death in plain terms, so that it may be properly classified.
 See instructions on back of certificates.
 AGE should be stated EXACTLY.

N.68407 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68407
 91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20)

2-FULL NAME

(a) RESIDENCE. NO.

Length of residence in city or town where death occurred

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in
 a hospital or institu-
 tion, give its NAME
 instead of street and
 number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Jan. 1922, to Oct. 17, 1922

that I last saw him alive on Oct. 16, 1922

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
 state (1) Means and Nature of Injury, and (2) whether Accidental,
 Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

P. HALLABER

Registrar

CT 17 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

ST.

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Williamston Hammond

6 DATE OF BIRTH (month, day, and year)

Sept. 3, 1839

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

83

1

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

John Hilley

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

J. L. Hammond 204 E 26th St

15 Filed

1922

ROBERT R. MAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1922, to Oct 16 1922.

that I last saw him alive on Oct 16 1922.

and that death occurred, on the date stated above, at 1:50 a.m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Ed Roy Stippler

ADDRESS

128 North Ave

Spec. - 1-10-21 - M & T - 1500 B

~~E~~ D 68409

31

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1713 Ethna ST. ... WARD

(Usual place of abode) St. Ward (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1922

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1922, to Oct 16, 1922, that I last saw her alive on Oct 15, 1922 and that death occurred, on the date stated above, at 10.15 A. M.

WIFE of Monroe Henry

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	24	1	22	

(a) Trade, profession or particular kind of work: *Housewife*

(c) **Name of employer**

10 NAME OF FATHER George Wilho

11 BIRTHPLACE OF FATHER (city or town) Beth
(State or country) Ind.

12 MAIDEN NAME OF MOTHER *Clara Block*

13 BIRTHPLACE OF MOTHER (city or town) Sal
(State or country) Ind

14 Informant Monroe Henry
(Address) 1713 68th St

15 Filed OCT 18 1922

..... (duration) yrs. 6 mos ds

CONTRIBUTORY
(Secondary)
..... (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Frey, M.D.

7/16, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL

MON. *Robt. Gibson* Oct 1, 1927

20 UNDERTAKER ADDRESS / 3

James A. Holmes Boston

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1841 Lorman ST., 15 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

No

6 DATE OF BIRTH (month, day, and year)

July 21/22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt. Md.

10 NAME OF FATHER

Eugene Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt. Md.

12 MAIDEN NAME OF MOTHER

Flora Milligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt. Md.

14

Informant (Address)

Flora Milligan
1841 Lorman St.

15

Filed

19

ROBERT R. HUNTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 8, 1922, to Oct 16, 1922,

that I last saw her alive on Oct 15, 1922

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro
Enteritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

9/16, 1922 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 203

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec. 6-9-19-H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____)

2-FULL NAME

(a) RESIDENCE. NO. _____

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds.

ST.: _____ WARD) _____

ST.: _____ WARD. _____

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX _____ 4 COLOR OR RACE _____ 5 Single, Married, Widowed, or Divorced (write the word) _____
6a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) _____ 7 AGE _____ Years _____ Months _____ Days _____ If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) _____ (State or country) _____

10 NAME OF FATHER _____ 11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) _____
12 MAIDEN NAME OF MOTHER _____ 13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) _____

14 Informant (Address) _____

15 File _____ Registrar _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) _____

17 I HEREBY CERTIFY, That I attended deceased from _____ to _____ that I last saw her alive on _____ and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis. (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY Cardiac Failure. (Secondary) (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) _____ M. D. _____
, 19 _____ (Address) _____

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL _____ DATE OF BURIAL _____

20 UNDERTAKER _____ ADDRESS _____

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

35 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 22, 1922, to Oct. 15, 1922.

that I last saw him alive on Oct. 15, 1922.

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

(Nephritis) Abdominal Rigidity
Effusion. Indefinite.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1934 - (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Cemetery Oct 18 1922

20 UNDERTAKER

Mrs Robert A. Elliott Oakland

15 Filed

OCT 18 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 N. Kershaw ST., 7 WARD)

2-FULL NAME

Frederick Johnson

(a) RESIDENCE NO.

1022 N. Kershaw ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jennie Johnson
Not known

6 DATE OF BIRTH (month, day, and year)

7 AGE

64

Years

Months

Days

If LESS than 1 day, — hrs or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Jobber

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Miss

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Beatrice Collins
1022 N. Kershaw St.

15

Filed

181922ROBERT R. HEATER
Bureau of Health
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 192217 I HEREBY CERTIFY, That I attended deceased from (about) Aug 9, 1921, to Oct 16, 1922, that I last saw him alive on Oct 2, 1922, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? urinalysis

(Signed)

, 19 (Address) 1904 E. Bay View

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel Cemetery

DATE OF BURIAL

Oct 19 1922

20 UNDERTAKER

Mrs Robert A ElliottADDRESS 1725Ashland

N. B.—WRITE PLAINLY. PHYSICIANS SHOULD STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3443 Jenkins Lane ST.: 9 WARD)

2-FULL NAME

Elmer William Wanner

(a) RESIDENCE. NO.

3443 Jenkins Lane

ST.: _____ WARD.

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos.

ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,

or Divorced (write the word)

Married

5a I (married, widowed, or divorced)

HUSBAND of

Ray Wanner

6 DATE OF BIRTH (month, day, and year)

May 15, 1928

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

34

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk in cigar store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

John Wanner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Mary Hoops

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14

Informant

(Address)

Ray Wanner
3443 Jenkins Lane

15

Filed

OCT 18 1922

ROBERT R. KROGER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

October 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from October 20, 1922 to October 16, 1922 that I last saw him alive on October 15, 1922 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema
Myocardial Insufficiency

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.
Chronic Interstitial Nephritis
Chronic Arterial Hypertension
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? W. G. Seyer

(Signed)

, 19 (Address)

541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Baltimore Cemetery

20 UNDERTAKER

George J. Ruth

DATE OF BURIAL

10/19/1922

ADDRESS

1735 Harford Ave

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3133 Leeds ST., 20th WARD)

2. FULL NAME

(a) RESIDENCE NO. 3133 Leeds ST., 20th WARD(Usual place of abode) Length of residence in city or town where death occurred 18 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Widowed6a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Johnson6 DATE OF BIRTH (month, day, and year) — 18617 AGE Years Months Days If LESS than 1 day, hrs. or min. 61

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Howard (State or country) County10 NAME OF FATHER Callies11 BIRTHPLACE OF FATHER (city or town) Howard Co. (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Howard Co. (State or country)14 Informant Mrs. Johnson (Address) 3133 Leeds15 Filed OCT 18 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16/192217 I HEREBY CERTIFY, That I attended deceased from 8/1, 1922, to 10/14, 1922, that I last saw him alive on 10/12, 1922, and that death occurred, on the date stated above, at 2:10 p.m. The CAUSE OF DEATH* was as follows:Pulmonary Tuberculosis (duration) yrs. 2 mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Lab. Spec. (Signed) R. H. Jackson, M. D.10/17/1922 Address 767 W. Annapolis

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Western Star Oct 19, 192220 UNDERTAKER Sam W. Chase ADDRESS 1400 N. W. 14th St.

N. B.—WRITE CLEARLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE SHOULD BE STATED EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificate.

68416 HEALTH DEPARTMENT—CITY OF BALTIMORE 68416
74-001 Registered No. C.

1-PLACE OF DEATH
City of BALTIMORE: (No. 580 Greenwillow St., 17 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Malinda J. Harris
(Residence in Baltimore: No. 580 Greenwillow St., 7 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female	4-COLOR OR RACE colored	5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed
6-DATE OF BIRTH about 1872 (Month) (Day) (Year)		
7-AGE 50 yrs., mos., ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Home Duties		
9-BIRTHPLACE (State or Country) Md.		
PARENTS	10-NAME OF FATHER Wm. Harris	
	11-BIRTHPLACE OF FATHER (State or Country) Md.	
	12-MAIDEN NAME OF MOTHER Jane Keger	
	13-BIRTHPLACE OF MOTHER (State or Country) Md.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margie Harris
(Address) 325 Hawthorne Rd.

15-
Filed OCT 18 1922
HARRY R. WEAVER
Registrar

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH
October 15, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(Duration) yrs., mos., ds.
CONTRIBUTORY (Secondary) no history
(Duration) yrs., mos., ds.
(Signed) J. T. Hennessy, M. D.
(Coroner)
Oct. 16, 1922 (Address) 280 Kensington Ave.
*State the Disease Causing Death, or, in deaths from violent causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs., mos., ds. In the State, yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL
Dunbar Cem Oct 18, 1922
20-UNDERTAKER, ADDRESS
Wm. H. Chase, 400 N. Charles St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A STATEMENT OF OCCUPATION. SICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

268417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

268417
123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #306-East-20th-St. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Annie Foy Mitchell

(a) RESIDENCE NO. 306-E-20th-Street. ST. 12 WARD (Resident)

(Usual place of abode) Length of residence in city or town where death occurred 64 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? 64 yrs. 6 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) March-27-1858

7 AGE Years 64 Months 6 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer) None (c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Robert M. Mitchell

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Foy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Miss ELLA V. FOY (aunt) (Address) 306-E-20-St. City

15 OCT 18 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct, 16th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 10th 1922, to Oct, 16th 1922, that I last saw her alive on Oct 16th 1922, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows: Impaction of the Common Bile Duct due to Gallstone causing Pyaemia (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Carrick, M. D. Oct 16 1922 (Address) 412 N. Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

GREENMOUNT CEMETERY OCT-19-22 ADDRESS

20 UNDERTAKER STEWART & MOWEN COMPANY 108 W. NORTH AVE. (WILLIAM F. WOODEN, (Signature))

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 W. Barre ST., 22 WARD)

2-FULL NAME

Lillie Washington

(a) RESIDENCE NO.

610 W. Barre

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female ColoredMarried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Samuel Washington

6 DATE OF BIRTH (month, day, and year)

June 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

House wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Solomon Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

md

12 MAIDEN NAME OF MOTHER

Emeline

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md

14

Informant (Address)

Samuel Washington
610 W. Barre

15

Filed

19

ROBERT R. BRANTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 5, 1922, to Oct 16, 1922.that I last saw him alive on Oct 15, 1922.and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia LobesCONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 10 ds.18 Where was disease contracted if not at place of death? HomeDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Chromic acid dye(Signed) C. H. F. M. D.1922 (Address) 7125 Sharp Street

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Auburn Cem.

20 UNDERTAKER

John H. Toadown

DATE OF BURIAL

Oct 18 1922

ADDRESS

142

N. B.—WRITE PLAINLY, WITH UNBROKEN LINES. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

N 68419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C 188-003

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *4* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Anton Neuman
(Residence in Baltimore: No. *Balt Highlands A.A. Co m 8* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married*
(Write the word)

6-DATE OF BIRTH, *Not known*
(Month) (Day) (Year)

7-AGE, *56* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Merchant*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Bohemia*

10-NAME OF FATHER, *Chas Neuman*

11-BIRTHPLACE OF FATHER, (State or Country), *Bohemia*

12-MAIDEN NAME OF MOTHER, *Anna Scharsky*

13-BIRTHPLACE OF MOTHER, (State or Country), *Bohemia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Josephine Neuman*
(Address) *Balt Highlands A.A. Co m 8*

15. *OCT 18 1922*
Filed, 1922, *J.A. Moore* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 15*, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest, autopsy or inquiry.* thereon and from the evidence obtained by said *inquest, autopsy or inquiry.* and that said deceased came to *his death* on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of skull

(Duration) yrs. mos. ds. *a few hours*

CONTRIBUTORY (Secondary) *Struck by auto*

(Signed) *J.R. Foran* (Coroner.)

10-17 1922 (Address) *117 N. Saratoga*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Oak Hill* DATE OF BURIAL, *Oct 18*, 1922

20-UNDERTAKER, *Grand Junction* ADDRESS, *1406 Highland*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3676 Falls Road ST., 13 WARD)

2-FULL NAME

Alexander H. Creamer

(a) RESIDENCE NO.

3676 Falls Road ST., 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 8 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Mary O. Creamer

6 DATE OF BIRTH (month, day, and year)

Feb. 12 - 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7684

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Saddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Alexander Creamer

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Maryland

12 MAIDEN NAME OF MOTHER

Ellen Humphrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Maryland

14

Informant (Address)

Mrs. Mary O. Creamer 3676 Falls Road

15

Filed 181922 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 1922 to Oct. 16 1922that I last saw him alive on Oct. 14 1922and that death occurred, on the date stated above, at 7:25 P. m.

The CAUSE OF DEATH* was as follows:

lung occiditisChr. Tubercular hepatitis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Arterio-sclerosis(duration) 1 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Emm S. Meyer, M. D.10/17, 1922 (Address) 7438 E. Mt. Plea

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount Cemetery Oct. 19 1922

20 UNDERTAKER

ADDRESS

Horace H. Burgee 363 Falls Rd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A FACT. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

268421

HEALTH DEPARTMENT—CITY OF BALTIMORE

268421

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N. Collington Ave., 6 WARD)

2-FULL NAME

Elizabeth Hennessey

(a) RESIDENCE No. 13 N. Collington Ave., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White 2 widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Thomas Hennessey.

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

68

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

10 NAME OF FATHER James Furlong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Agnes E. Hennessey (Address) 13 N. Collington Ave.

15 Filed 18 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 16 22 1922 to Oct 16 1922

that I last saw her alive on Oct 16 1922

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Val. Dis. heart - Mitral and Aortic Stenosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Embolism of a far minute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical and

(Signed) R. A. M. D.

, 19 (Address) 6 N. Perry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Catholic Cemetery

20 UNDERTAKER

John A. Moran 3000 E. Balto St.

DATE OF BURIAL

Oct 19 1922

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 George ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 930 Penn. Ave. St.; 48 yrs., 5 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Col.

5-STATUS,

Married
Never
Or Divorced
(Write the word.)

6-DATE OF BIRTH,

May 30, 1894
(Month) (Day) (Year)

7-AGE,

48 yrs., 5 mos. 15 ds.If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

ChauffeurSelf9-BIRTHPLACE,
(State or Country),Md.

10-NAME OF FATHER,

Simon Clemmens11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER

Catharine Thompson13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Margaretta Clemmens
930 Penn. Ave.

15-

Filed

OCT 18 1922

101

ROBERT R. KAUFER

Registrar.

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 15, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Jan 1922, to Oct 15 - 1922, that I saw him alive on Oct 15 - 1922, and that death occurred, on the date stated above, at 2.20 PM

The CAUSE OF DEATH* was as follows:

Organic Heart(Duration).....yrs. 9 mos.ds.CONTRIBUTORY
(Secondary)

(Duration).....yrs.mos.ds.

(Signed)

H. N. King M. D.
10-17, 1922 (Address) 65-1 N. Lombard

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

W. C. Cuthbertson Oct 18, 1922
Anna H. Hensley 578
Middle

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

068423 HEALTH DEPARTMENT—CITY OF BALTIMORE 068423

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 McCall St. ST. WARD)

2-FULL NAME Michelle Custer

(a) RESIDENCE. No. 1430 McCall St. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

OCT 18 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 12 1922, to Oct 15 1922, that I last saw him alive on Oct 14 1922, and that death occurred, on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Illeg Colitis

(duration) yrs. mos. 6 ds. CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) Chas. B. Blount, M.D.

191922 (Address) 1504 McCall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Ambrose Cem Oct 18 1922

20 UNDERTAKER ADDRESS

Sam Henry 1324

U. S. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

068424 HEALTH DEPARTMENT—CITY OF BALTIMORE 068424
100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. *Johns Hopkins Hosp 14* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *James Whitney*
(Residence in Baltimore: No. *1932 Brent St* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Black* 5-*Single, Married, Widowed, or Divorced.* (Write the word.)
6-DATE OF BIRTH. 1.
(Month) (Day) (Year)
7-AGE. *10* yrs. mos. ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Child*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE. (State or Country). *Baltimore*
10-NAME OF FATHER. *Henry Jones*
11-BIRTHPLACE OF FATHER. (State or Country).
12-MAIDEN NAME OF MOTHER. *Mary Whitney*
13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Johns Hopkins*
(Address)

15-
Filed. *OCT 18 1922* 1922 *ROBERT R. WALTER* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Oct 7* 192*2*
(Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or Inquiry.) find that said deceased came to *death* on the day stated above.
The CAUSE OF DEATH* was as follows:
Potential Secondary Pneumonia
P. M.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) *John S. Rutter* M. D. (Coroner)
10-10 192*2* (Address) *5086 North Ave*
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence.
19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
HOPKINS HOSPITAL *Oct 17* 192*2*
20-UNDERTAKER. ADDRESS
Central Undertaking Co

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

068425 HEALTH DEPARTMENT—CITY OF BALTIMORE 068425
100-001
CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. *Johns Hopkins Hosp 6* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Clarence Boykin*
(Residence in Baltimore: No. *132 W. Washington* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.		
3-SEX <i>Male</i>	4-COLOR OR RACE <i>White</i>	5-Single, Married, Widowed, or Divorced. <i>Married</i> (Write the word.)
6-DATE OF BIRTH 1..... (Month) (Day) (Year)		
7-AGE yrs. <i>7</i> mos. ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <i>Chief</i> (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE. (State or Country). <i>Balto Md</i>		
PARENTS.	10-NAME OF FATHER. <i>Clarence Boykin</i>	
	11-BIRTHPLACE OF FATHER. (State or Country).	
	12-MAIDEN NAME OF MOTHER. <i>Mary</i>	
	13-BIRTHPLACE OF MOTHER. (State or Country).	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Johns Hopkins Hosp*
(Address)

15-
Filed *OCT 18 1922* *ROBERT R. KRAUTER*
Bureau of Vital Statistics Registrar.

CORONER'S CERTIFICATE OF DEATH.		
16-DATE OF DEATH. <i>Oct 6</i> 192 <i>2</i> (Month) (Day) (Year)		
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>inquiry</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>inquest</i> (Inquest, autopsy or inquiry.) and that said deceased came to <i>death</i> on the day stated above. The CAUSE OF DEATH* was as follows: <i>Pneumonia</i> <i>Probably Bronchial</i> (Duration) yrs. mos. ds. CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) <i>John H. Miller</i> M. D. (Coroner.) <i>10-17</i> 192 <i>2</i> (Address) <i>508 E. North Ave</i> *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. 18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?		
Former or usual residence		
19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.	
<i>JOHNS HOPKINS HOSPITAL</i>	<i>Oct 17</i> 192 <i>2</i>	
20-UNDERTAKER.	ADDRESS	
<i>Funeral Home</i>	<i>Health</i>	

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital*)ST.: *23* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rose Felser

(a) RESIDENCE. No.

1025 S. Charles

ST.: WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds.How long in U. S., if of foreign birth *Life* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

24

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Felser

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Rachel Margolis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Hosp

15

Filed

OCT 18 1922

ROBERT S. KAUTER, Registrar

Social Permit Mark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/18

1922

17

I HEREBY CERTIFY, That I attended deceased from *Sept. 24*, 1922, to *Oct. 18*, 1922.that I last saw her alive on *Oct. 18*, 1922.and that death occurred, on the date stated above, at *6:45 a. m.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(duration) yrs. *10* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Morris Gellman*, M. D.10/18, 1922 (Address) *Hebrew Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hebrew Mass Road**10/18* 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

268427 HEALTH DEPARTMENT—CITY OF BALTIMORE 268427
Eden
74-009

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1824 Ashland Ave St. 7

2-FULL NAME Robert Eden

(Residence in Baltimore: No. 1824 Ashland Ave

REGISTERED No. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May 7, 1849 (Month) (Day) (Year)

7-AGE, 73 yrs. 5 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, None (b) General nature of industry, business, or establishment in which employed (or employer), Formerly, Buckle

9-BIRTHPLACE, (State or Country), Balt., Md.

10-NAME OF FATHER, Mark Eden

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Jane

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Eden (wife)

(Address) 1824 Ashland Ave

15- ROBERT R. KRAUTER, Registrar.

Filed OCT 18 1922 191.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 16, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable apoplexy. Had left sided paralysis for 30 yrs. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. H. Patterson M. D. (Coroner.) 10-276 (Address) 108 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Baltimore County Oct 19, 1922

20-UNDERTAKER, ADDRESS, Wm. H. Hatley 8154 Ashington Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Taney Road, Mt. Washington ST. 12 WARD)

2-FULL NAME

Roxana Hay Mansfield

(a) RESIDENCE NO.

Tudor Hall
University Parkway

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

D. Clifford Mansfield

6 DATE OF BIRTH (month, day, and year)

July 21st 1860

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

62

2

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md.

10 NAME OF FATHER John C. Hay

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Baltimore
Md.

12 MAIDEN NAME OF MOTHER Sarah H. Keyser

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore
Md.

14

Informant
(Address)D. Clifford Mansfield
4 & 6 W. Fayette St.

15

OCT 18 1922

ROBERT R. MAUTER

Registrar

Burial Permit No.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15th 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct 3 1922 to Oct 15 1922

that I last saw her alive on Oct 15 1922

and that death occurred, on the date stated above, at 11.10 P.m.

The CAUSE OF DEATH* was as follows:

Aphasia & progressive paralysis
due to slow leakage. - Probably
Thrombus.

(duration) yrs. mos. 13 ds.

CONTRIBUTORY
(Secondary)diabetes mellitus
(duration) 2 or 3 yrs. - mos. - ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? no

What test confirmed diagnosis? Urinary &c.

(Signed) M. B. Mansfield, M. D.

10/16/22 Address) 626 N. Gilmore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Lorraine Cemetery

Oct 18th 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3057 W. North Ave. ST. 15 WARD)

2. FULL NAME

Mary E. Ryan

(a) RESIDENCE NO.

3057 W. North Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

William H. Ryan

6 DATE OF BIRTH (month, day, and year) Jan. 30th 1850

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

72 8 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

10 NAME OF FATHER William Joice

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Stall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.14 Informant M. Virginia Ryan
(Address) 3057 W. North Ave.

15 OCT 18 1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17th 19 22

17 I HEREBY CERTIFY, That I attended deceased from

October 15th 1922 to October 17th 1922.that I last saw ~~her~~ alive on October 16th 1922.

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Acute Sclerosis

Central embolism

No. 1000000000

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Samuel M. Munnier*, M. D.

10/17/22 Address 714 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL New Cathedral Cem Oct 19 1922

20 UNDERTAKER

Joseph B Cook 1003 N. Balt

10.68430 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68430

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3008 E. Pratt ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Elizabeth B. Black

(a) RESIDENCE NO. 3008 E Pratt ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John J. Black

6 DATE OF BIRTH (month, day, and year)

Jan. 16, 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

59

9

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George Berlett

11 BIRTHPLACE OF FATHER (city or town)

Germany

12 MAIDEN NAME OF MOTHER

Thunigunda Dreyer

13 BIRTHPLACE OF MOTHER (city or town)

Germany

14

Informant

Mrs Mammie L. Leithaler

(Address)

3008 E. Pratt St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1922, to Oct. 16, 1922,

that I last saw him alive on Oct 16, 1922,

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Ventricular Fibrillation

CONTRIBUTORY (duration) 2 yrs. mos. ds.

(Secondary) Anterior Abdominal

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Lungs

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) J. Sander, M.D.

1922 (Address) 330 N. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Carmel Cemetery Oct 19 1922

20 UNDERTAKER

J. Sander 1210 North St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 18 1922

BIRTH PERMIT CLERK

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (JOHNS HOPKINS HOSPITAL, ST., 7 WARD)

2-FULL NAME

Cob. Aubrey S. Fowler

(a) RESIDENCE NO.

Little Rock Ark, ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown

How long in U. S., if of foreign birth?

Yrs. Mos. Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)

Male White Married

5 If married, widowed, or divorced
HUSBAND of

Mrs. Rosie S. Fowler (wife).

6 DATE OF BIRTH (month, day, and year)

Oct. 30, 1848

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

79

11

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Real Estate Manager

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Ohio

10 NAME OF FATHER

John Fowler

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Amanda Burdfield

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Ohio

14

Informant
(Address)

JOHNS HOPKINS HOSPITAL

15

Filed

Robert F. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 15, 1922, to Oct 18, 1922,

that I last saw him alive on Oct 18, 1922,

and that death occurred, on the date stated above, at 4:45 A. M.

The CAUSE OF DEATH* was as follows:

Benign prostatic hypertrophy

(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

yes

Date of Sept 18, 1922

Was there an autopsy?

yes

What test confirmed diagnosis?

autopsy

(Signed)

August C. Shaw, M. D.

1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Little Rock Ark.

DATE OF BURIAL

Oct 19, 1922

20 UNDERTAKER

Thurgood, E. H. House Co

ADDRESS

McClure

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68432

CERTIFICATE OF DEATH.

162
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 18 Mortimer Ave to one ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 18 Mortimer Ave to one St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. W. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

6-DATE OF BIRTH. Oct 2, 1922 (Month) (Day) (Year)

7-AGE, yrs. mos. ds. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, Otis Thomas Butterworth

11-BIRTHPLACE OF FATHER (State or Country), Petersburg Va

12-MAIDEN NAME OF MOTHER, Nadege J. McNally

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 2, 1922, to Oct 18, 1922,

that I saw him alive on Oct 17, 1922,

and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Unilateral Hemorrhage
Gastric (Duration) 9 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. 6 mos. 6 ds.

(Signed) C. B. Carter M. D.

Oct 18, 1922 (Address) 5016 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, McSpedee McChenit

DATE OF BURIAL, Oct 19, 1922

20-UNDERTAKER, Carter and Co

ADDRESS, 1423 N. Lafayette

OCT 18 1922

Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS SHOULD STATE VERY EXACTLY. Exact statement of OCCUPATION very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.68433 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68433
74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Little Sisters of the Poor ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Gaines.

(a) RESIDENCE. NO. Preston Valley ST. (Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow of

5a If married, widowed, or divorced HUSBAND of Henry Gaines (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1833

7 AGE Years 89 Months - Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Washington Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Rebecca Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Frances (Address) Little Sisters of the Poor

15 Filed 10-19-21 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1921

17 I HEREBY CERTIFY, That I attended deceased from 10:00 a.m. to 10:00 a.m., 1921

that I last saw her alive on Oct 15, 1921

and that death occurred, on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY Cerebral apoplexy (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

16, 1921 (Address) 1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Laurel Cemetery Oct 19 - 1921

20 UNDERTAKER ADDRESS

John G. Bailey 1421 Jefferson St.

of infor-
Every
state
PUPA-
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement of death should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

68434

HEALTH DEPARTMENT—CITY OF BALTIMORE

68434

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hospital* ST., *4* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles Coligny*

(a) RESIDENCE NO. *217 Hanover*

(Usual place of abode)

ST.,

WARD

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred *40 years*

How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male white Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec. 13, 1854*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 18 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 17, 1922* to *Oct 18, 1922*, that I last saw him alive on *Oct 18, 1922*

and that death occurred, on the date stated above, at *10:20 A.M.*

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

CONTRIBUTORY (Secondary) *Cerebral embolus* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Dead Room*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Ed. Harman*, M. D.

, 19 (Address) *Franklin Sq. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cent

10-20 1922

20 UNDERTAKER

ADDRESS

Wm Coolidge

502 E. P.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 N. Harmount ST. WARD 19)

2-FULL NAME

(a) RESIDENCE NO. 1835 N. Harmount ST. WARD 19

(Usual place of abode)

Length of residence in city or town where death occurred

Life mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 22 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Milton H. Griffin

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Genevieve Adkins

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Va

14

Informant (Address)

Milton H. Griffin
1835 N. Harmount

15

1-10-21

ROBERT P. HARTMAN

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1922

17

I HEREBY CERTIFY That I attended deceased from

Aug 21 1922 to Oct 18 1922

that I last saw him alive on Oct 17 1922

and that death occurred, on the date stated above, at 12 10 P.M.

The CAUSE OF DEATH was as follows:

Mediastinitis (tubercular)

Empyema

Bronchial fistula

(duration)

yrs. yrs. 2 mos. mos.

ds. ds.

CONTRIBUTORY (Secondary)

(duration)

yrs. yrs. 3 mos. mos.

ds. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical

(Signed) Edw. J. Coolidge, M. D.

10/18/22 (Address) 24 N. Sutton Ave.

*State the Disease Causing Death, in deaths from Violent Causes, state (1) Means and Nature of injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REINTERMENT

MOVAL

Woodlawn

DATE OF BURIAL

10-20 1922

20 UNDERTAKER

Wm. Cook

ADDRESS

502 E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE *20.68436**20.68406*

CERTIFICATE OF DEATH.

159-003

1-PLACE OF DEATH

South Baltimore Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. *22* WARD)

2-FULL NAME

Baby Virginia Harper

(a) RESIDENCE NO.

1103 Patapsco

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *10* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female white single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec. 6-1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Baby

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Harry W. Harper

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Julia M. Inch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Rochester Md.

14

Informant (Address)

Harry W. Harper 1103 Patapsco

15

Filed

Robert P. Escribano

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 18 1922*17 I HEREBY CERTIFY, That I attended deceased from *August 24*, 19*22*, to *October 18*, 19*22*, that I last saw her alive on *October 18*, 19*22*, and that death occurred, on the date stated above, at *8:49* m.

The CAUSE OF DEATH* was as follows:

Malnutrition due to Congenital malformation of stomach(duration) yrs. *2* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death? Date of

Was there an autopsy?

yes

What test confirmed diagnosis?

distention of stomach

(Signed)

John A. Connors, M. D.

, 19

(Address) *South Baltimore Gen Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill

DATE OF BURIAL

10-20 1922

20 UNDERTAKER

Wm. Cook

ADDRESS

502 E. North

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

(Pancoast) ✓
 20.68437 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 23 Williamson ST. 23 WARD)

REGISTERED NO.

(If death occurred in
 a hospital or institu-
 tion, give its NAME
 instead of street and
 number.)

2-FULL NAME

Mary Nellie Pancoast

(a) RESIDENCE. NO.

23 Williamson

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Albert R. Pancoast

6 DATE OF BIRTH (month, day, and year)

Sept-6-1865

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

57

1865

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Housewife

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

John L. Coulter

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

not known

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

not known

14

Informant
(Address)

Anna G. Owens

23 Williamson St.

15

Filed

19

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-18 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct 9th, 1922, to Oct 17th, 1922.that I last saw her alive on Oct 17th, 1922.

and that death occurred, on the date stated above, at 11:55 PM.

The CAUSE OF DEATH* was as follows:

Paralysis (Hemiplegia)

second attack

CONTRIBUTORY
(Secondary)duration yrs. mos. ds.
refractive & High Blood Pressure

(duration) not known mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? renal test

(Signed) Henry B. Kolb M. D.

Oct 18/22 (Address)

1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill

10-20-1922

20 UNDERTAKER

ADDRESS

Wm Cook

502 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

OCT 18 1922

Burial Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68438 HEALTH DEPARTMENT—CITY OF BALTIMORE 68438

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *John Hopkins Hosp* St. *22* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *332 Dover St* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Brown

5-*Single*,
Married,
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH.

Aug 8

(Month)

(Day)

(Year)

7-AGE,

2

9

ds.

If LESS than 1 day,

..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.....
(b) General nature of industry,
business, or establishment in
which employed (or employer).....

Child

9-BIRTHPLACE,

(State or Country),

Baltimore

PARENTS.

10-NAME OF
FATHER,

Boyer Pennington

11-BIRTHPLACE
OF FATHER,

(State or Country),

Md.

12-MAIDEN NAME
OF MOTHER,

Lena Johnson

13-BIRTHPLACE
OF MOTHER,

(State or Country),

Md.

11-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

John Hopkins Hosp.

(Address),

Baltimore

15-

Filed

OCT 19 1922

192

ROBERT R. KRAUTER,

Bureau Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 17

(Month)

(Day)

192*2*
(Year)

17- I HEREBY CERTIFY, That I took charge of the
remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-
topsy or inquiry.) and that said deceased came to..... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Conjunctive Syphilis

Antipyretic

(Duration)..... yrs., mos., ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs., mos., ds.

(Signed)..... M. D.

(Coroner.)

10-1-8-1922 (Address) *508 G. North Ave*

*State the Disease Causing Death, or, in deaths from Violent
Causes, state (1) Means of Injury; and (2) whether Accidental,
Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Tran-
sients, or Recent Residents).

At place of death..... yrs., mos., ds. In the State..... yrs., mos., ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Int Zion Cemetery

Oct 19

20-UNDERTAKER,

ADDRESS

Wm Gerth Hoops 406 W. Calvary St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

OCT 19 1922

ROBERT R. RAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Oct 13 1922 to Oct 17 1922 that I last saw her alive on Oct 17 1922 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Ac Uremia

CONTRIBUTORY (Secondary)

Ac Parachymatous nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cannot say

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary tests

(Signed) Edw. Shopt M.D.

10/17/1922 (Address) 1812 David Hill av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERSONAL RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

1922

ROBERT R. MAUTER
Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

ST.

WARD)

ST.

WARD.

(If nonresident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

6/2 1922, to 10/18 1922

that I last saw ~~her~~ alive on 10/18 1922

and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Phty & Pulmonals

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? ☒ Date ofWas there an autopsy? ☒

What test confirmed diagnosis?

(Signed) J. R. R. M. D.

10/18/22 Address 2139 E. N. C.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

Oct 21 1922

20 UNDERTAKER

ADDRESS 1725

Enre Robert A. Elliott

Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

ST.: 8

WARD)

ST.: 8

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from and on about, Sep. 16/10/1922 that I last saw him alive on 16/10/1922 and that death occurred, on the date stated above, at 11 A. M.

THE CAUSE OF DEATH* was as follows:

Working defunct - The patient evidently died peacefully - no definite disease was traceable (duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

18/10/22 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Gebhart
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Union Memorial Hospital* ST. *13* WARD)

2-FULL NAME

Morris Gibhart

(a) RESIDENCE NO.

934 Brook Lane

ST.

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos.ds. How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*Mrs M. Gibhart*

6 DATE OF BIRTH (month, day, and year)

1841

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*81*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Russia*

10 NAME OF FATHER

*Isaac Gibhart*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Russia*

12 MAIDEN NAME OF MOTHER

*An Kom*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Russia*14 Informant
(Address)*Root*

15

Filed

19

ROBERT R. MAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 18, 1922*

17

I HEREBY CERTIFY, That I attended deceased from
October 12, 1922 to *October 18, 1922*.that I last saw him alive on *October 18, 1922*.and that death occurred, on the date stated above, at *2:30 A. M.*

The CAUSE OF DEATH* was as follows:

*pneumonia following
operation for strangulated
hernia*(duration) yrs. mos. *2* ds.CONTRIBUTORY
(Secondary)*pneumonia*
(duration) yrs. mos. *3* ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? *yes* Date of *Oct. 13, 1922*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

M. D.

1922

(Address)

Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Back View of**1922*

A UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

268444
1-PLACE OF DEATH

CERTIFICATE OF DEATH

90 268444
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7011)

WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

70 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY that I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Bronch. Pneumonia & Pleurisy

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

Signed:

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 N. Appleton ST., 15 WARD)

2-FULL NAME

Annie Medary Hanna

(a) RESIDENCE NO.

1805 N. Appleton

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

75 yrs.mos. 22 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Henry W. Hanna

6 DATE OF BIRTH (month, day, and year)

Sept. 26 1847

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

75—22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto. Md.

(State or country)

10 NAME OF FATHER

Alexander Medary

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Lemina Hardy

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

14

Informant

(Address)

Henry W. Hanna1805 N. Appleton St.

15

Filed

19

ROBERT R. MAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Feb, 1922, to Oct 18, 1922.that I last saw him alive on Oct 17, 1922.and that death occurred, on the date stated above, at 7²⁰ a m.

The CAUSE OF DEATH* was as follows:

Renal CancerCONTRIBUTORY (Secondary) Urticaria Regurgitation (duration) yrs. mos. ds.18 Where was disease contracted Don't know if not at place of death?Did an operation precede death? NO Date ofWas there an autopsy? NOWhat test confirmed diagnosis? Symptoms and lab.(Signed) Henry Russell, M. D., 19 (Address) 3403 Groveland St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Churchville Harford Co MdADDRESS 1922

20 UNDERTAKER

Harry W. EhlenW. Northan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D68446

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68446
91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 N Payson St. WARD)

2-FULL NAME

Sudley Portieux Barnette

(a) RESIDENCE. No. 212 N Monroe

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred 40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Roussard J Barnette

6 DATE OF BIRTH (month, day, and year)

Oct 19 1843

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

78+

78

11

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Gloucester Co Va

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Portieux

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant
(Address)Larkin Barnette
212 N Payson

15

Filed

19

ROBERT R. BAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 17 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 30 1922, to Oct 17 1922.

that I last saw him alive on Oct 17 1922.

and that death occurred, on the date stated above, at 7:15 P. M.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis
Senile DementiaCONTRIBUTORY
(Secondary)

(duration)

yrs.

6 mos.

ds.

(duration)

yrs.

12 mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: Bay D. McCleary, M. D.

Address: 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Roulon Park Cem

DATE OF BURIAL

Oct 20 1922

20 UNDERTAKER

Wm J. Hickman Sons

ADDRESS

North Va

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 arlington ave 90 WARD)2-FULL NAME Thomas Mulligan(a) RESIDENCE. No. 1006 arlington ave 90 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) widower5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) April 12 18577 AGE Years 65 Months 6 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md10 NAME OF FATHER William Mulligan11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md12 MAIDEN NAME OF MOTHER Lucy Berling13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md14 Informant Mr Richard Fry
(Address) 1006 arlington ave 90 WARD15 Filed 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 192217 I HEREBY CERTIFY, That I attended deceased from Oct 3, 1922, to Oct 18, 1922.that I last saw him alive on Oct 18, 1922.and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis
and cardiac
degeneration(duration), 1 yrs. mos. ds.CONTRIBUTORY Insult
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Died thereDid an operation precede death? No Date of XWas there an autopsy? NoWhat test confirmed diagnosis? X Examination(Signed) J. R. R. R. M. D., 19 (Address) Glyndon Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Piney Grove Cemetery Oct 20 192220 UNDERTAKER Balto Co Md ADDRESSJ. F. Eline Reston Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 St Carey ST.: 15 WARD)

2-FULL NAME

(a) RESIDENCE. No. 1625 St Carey ST.,

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds.How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 ~~Single~~, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

(or) WIFE OF

Elizabeth M. Schefferman6 DATE OF BIRTH (month, day, and year) April 26 18587 AGE Years 64 Months 5 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 18 1922 1917 I HEREBY CERTIFY, That I attended deceased from July 4, 1922, to Oct 18, 1922, that I last saw him alive on Oct 18, 1922, and that death occurred, on the date stated above, at 6:25 p. m.

The CAUSE OF DEATH* was as follows:

Infection of the foot
gangrene(duration) yrs. 3 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted Do not know if not at place of death?Did an operation precede death? no Date of ^Was there an autopsy? none

What test confirmed diagnosis?

(Signed)

E. M. Little, M. D.
OCT 19 1922 (Address) 2129 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

EDMONDSON AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

n. CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1355 Leachman

ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Young

(a) RESIDENCE. NO. 1355 Leachman

ST.: WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ellen Young

6 DATE OF BIRTH (month, day, and year)

Month 9, 1836

7 AGE

Years

Months

Days

If LESS than 1 day... hrs. or min.

76

6

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ex School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Harriet Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14 Informant (Address)

Ellen Young, 1355 Leachman St.

15

Filed OCT 19 1922

ROBERT R. KAUFER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 16 1922 to Oct 18 1922

that I last saw him alive on Oct 18 1922

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) yrs. 6 mos. 7 ds.

CONTRIBUTORY (Secondary)

Age, Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William H. Wright M. D.

19, 1922 (Address) 1209 Prosser Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

National Cemetery Oct 20 1922

20 UNDERTAKER

ADDRESS

Samuel Wright 1364 Carey

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RECORD—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Baltimore, Md.

CITY OF BALTIMORE: (No. 1134 Pennsylvania Ave. ST., 17 WARD)

2-FULL NAME

Marcus Kynce

(a) RESIDENCE NO. 1134 Pennsylvania Ave., ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Gold married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fabr.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Don't know

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Don't know

14

Informant (Address)

Daniel Easton 216 E. ...

15

Filed

, 19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17, 19 22.

I HEREBY CERTIFY, That I attended deceased from Aug. 29, 19 22, to Oct. 17, 19 22, that I last saw him alive on Oct. 17, 19 22, and that death occurred, on the date stated above, at 8:15 P.m.

The CAUSE OF DEATH* was as follows:

Aneurysm (Aortae)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

Edema of Lung (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA L
Don't know bur

Oct 19, 22

20 UNDERTAKER

Daniel Easton

ADDRESS 916

64 cr

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 17 WARD)2-FULL NAME Aelxander Sharpe(a) RESIDENCE NO. 585 Walnut St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of None6 DATE OF BIRTH (month, day, and year) 18857 AGE Years Months Days If LESS than 1 day, hrs. or min.
37 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpet Sweeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Mr. Sharpe11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Rhetta Rolins13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Municipal Hospital. Records,
(Address)15 Filed 1922 ROBERT H. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 16 19 2217 I HEREBY CERTIFY, That I attended deceased from October 7, 1922, to October 16, 1922.that I last saw him alive on October 16, 1922.and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of PancreasCONTRIBUTORY (Secondary) Carcinomatous (duration) yrs. 6 mos. 3 ds.
peritonium (duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? YesWhat test confirmed diagnosis? Autopsy
(Signed) Clyde McNeill, M. D.10/17/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mount Auburn Cem.

20 UNDERTAKER

Daniel E. Egan

DATE OF BURIAL

Oct 19, 22

ADDRESS

Pa. av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—F-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 423 S Durham ST., V WARD)

2-FULL NAME

Helen Wojtysiak

(a) RESIDENCE NO.

423 S Durham ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 11 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

1

8

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Wojtysiak

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Frances Brygid

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Mrs. Frances Wojtysiak
423 S Durham

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct 17, 19 22, to Oct 18, 19 22

that I last saw him live on Oct 25, 19 22

and that death occurred, on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Lupus Dysenteria

(duration)

yrs.

mos

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1918 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Rosary

Oct 19 19 22

20 UNDERTAKER

ADDRESS

John M. Weber 1803 Bunk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1090 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Rossiter ave ST. 27 WARD)

2-FULL NAME William Henry Holmes

(a) RESIDENCE. No. 507 Rossiter ave ST. 27 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Clara May Holmes

6 DATE OF BIRTH (month, day, and year) Nov 7 1873

7 AGE Years 48 Months 11 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) md.

10 NAME OF FATHER Samuel Holmes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Mary Ogilvie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore
md.

14 Informant Clara May Holmes
(Address) 507 Rossiter ave.

15 Filed 1919 1922 ROBERT R. REANTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8 1922, to Oct 17 1922.

that I last saw him alive on Oct 17 1922.

and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Emphysema

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. S. Jones M. D.

18. 1922 (Address) 720 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Presbyterian Cemetery Grovers Oct 20 1922

20 UNDERTAKER ADDRESS

Chas. G. Black 742 W North Ave

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Pulmonary - not Tubercular.

MARGIN RESERVED FOR BUREAU OF HEALTH RECORDS. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1 10-21 MAT 1500 Bks.

68454 HEALTH DEPARTMENT—CITY OF BALTIMORE 68454
Baumson
90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 300 N. Bond ST., 6 WARD)

2-FULL NAME

Sarah Baumson

(a) RESIDENCE NO.

300 N. Bond

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

William Baumson

6 DATE OF BIRTH (month, day, and year)

Unknown/88/

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Unknown

14

Informant
(Address)

William Baumson
300 N. Bond St.

15

Filed

1919

Robert H. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1922 to Oct. 1922

that I last saw him alive on Oct. 13, 1922

and that death occurred, on the date stated above, at 8:10 P. M.

The CAUSE OF DEATH* was as follows:

General Dropsy
(duration) yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of 10/17/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. S. ... M. D.

, 19 (Address) 2818 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL Ashbury Cemetery Oct. 20 1922

20 UNDERTAKER

ADDRESS

Chris. H. Johnson 416 N. Caroline

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Cardiac - Mitral
Insufficiency one year
No other history.*

MARGIN RESERVED FOR INFORMATION. Every item of information should be stated EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

268455 HEALTH DEPARTMENT—CITY OF BALTIMORE 268455

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 777 N. Collington ST., 129 WARD)

2-FULL NAME

Sarah J. Leatherbury

(a) RESIDENCE No.

Deale P.O. U.A. Co. Md.

(Usual place of abode)

Length of residence in city or town where death occurred

0 yrs. 1 mos. 9 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frank O. Leatherbury

6 DATE OF BIRTH (month, day, and year)

10/31/1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

11

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Somerset Co. Md

10 NAME OF FATHER

George W. Windsor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Somerset Co. Md

12 MAIDEN NAME OF MOTHER

Sarah Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Somerset Co. Md

14

Informant (Address)

Leonard E. Mason 777 N. Collington Ave

15

Filed

ROBERT R. MAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 16, 1922, to Oct 19, 1922.

that I last saw her alive on October 18, 1922.

and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uremic Coma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

h

Did an operation precede death?

h

Was there an autopsy?

h

What test confirmed diagnosis?

Chemical

(Signed) Milton P. Hill, M. D.

19 (Address) 4210 N. Ruston Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL Deale U.A. Co. Md 10/19/22

20 UNDERTAKER

ADDRESS

Wm. Coats, 5026 E. North Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68456 HEALTH DEPARTMENT—CITY OF BALTIMORE 68456
88-003
1-PLACE OF DEATH
City of BALTIMORE: (No. *University Hospital* St. *12* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Alfred J. Gall, Jr.*
(Residence in Baltimore: No. *4002 Old York Road*, St. *6*, yrs. *6* mos. *6* ds.)

PERSONAL AND STATISTICAL PARTICULARS.
3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Single* (Write the word.)
6-DATE OF BIRTH, *April 9, 1916* (Month) (Day) (Year)
7-AGE, *6* yrs. *6* mos. *6* ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer).
9-BIRTHPLACE, (State or Country), *Baltimore*
PARENTS.
10-NAME OF FATHER, *Alfred J. Gall*
11-BIRTHPLACE OF FATHER, (State or Country), *Baltimore*
12-MAIDEN NAME OF MOTHER, *Marion Miller*
13-BIRTHPLACE OF MOTHER, (State or Country), *Baltimore*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Alfred J. Gall*
(Address) *4002 Old York Road*

15-FILED *OCT 19 1922* 1922
Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.
16-DATE OF DEATH, *Oct 17, 1922* (Month) (Day) (Year)
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquest, autopsy or inquiry.* thereon and from the evidence obtained by said *Inquest, autopsy or inquiry.* find that said deceased came to *her* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Ruptured Spleen
(Duration) *a few hours* yrs. *0* mos. *0* ds.
CONTRIBUTORY *Run over by Auto Truck*
(Secondary) (Duration) *10-19* yrs. *0* mos. *0* ds.
(Signed) *H. K. Gorman* M. D. (Coroner.)
10-19 1922 (Address) *147 N. Varadero St.*
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, *0* yrs. *0* mos. *0* ds. In the State, *0* yrs. *0* mos. *0* ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, *St. Paul's Cathedral* DATE OF BURIAL, *Oct 20, 1922*
20-UNDERTAKER, *C. A. Wiedefeld* ADDRESS, *301 E. 22 St.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Peiser

D68457 HEALTH DEPARTMENT—CITY OF BALTIMORE D68457

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 3403 Piedmont Ave Ward 15) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Peiser

(Residence in Baltimore: No. 3403 Piedmont Ave St.; yrs. 50 mos. 50 ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX. <u>Male</u>	4-COLOR OR RACE. <u>White</u>	5-STATUS. <u>Married</u> (Write the word.)	16-DATE OF DEATH. <u>October 17,</u> 192 <u>2</u> (Month) (Day) (Year)	
6-DATE OF BIRTH. <u>Sept 15</u> 18 <u>86</u> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <u>inquest</u> thereon and from the evidence obtained by said <u>inquest</u> and that said deceased came to <u>his</u> death on the day stated above. The CAUSE OF DEATH* was as follows: <u>acute gastro-enteritis</u> (Duration) <u>2 hrs.</u> yrs. <u>2</u> mos. <u>2</u> ds.	
7-AGE. <u>66</u> yrs. <u>1</u> mos. <u>2</u> ds. If LESS than 1 day, <u>hrs.</u> or <u>min.</u>			CONTRIBUTORY (Secondary) <u>aspirated</u> (Duration) <u>2 hrs.</u> yrs. <u>2</u> mos. <u>2</u> ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <u>Tailor</u>			(Signed) <u>J. J. Hennessy</u> M. D. (Coroner.) <u>Oct. 18, 1922</u> (Address) <u>2802 Edmondson Ave</u>	
9-BIRTHPLACE. (State or Country). <u>Germany</u>			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
PARENTS.	10-NAME OF FATHER. <u>Don't know</u>	11-BIRTHPLACE OF FATHER. (State or Country). <u>Don't know</u>	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death <u>15</u> yrs. <u>50</u> mos. <u>50</u> ds. In the State <u>15</u> yrs. <u>50</u> mos. <u>50</u> ds.	
	12-MAIDEN NAME OF MOTHER. <u>Don't know</u>	13-BIRTHPLACE OF MOTHER. (State or Country). <u>Don't know</u>	Where was disease contracted, if not at place of death?	
	14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>Miss Anna Peiser</u> (Address) <u>3403 Piedmont Ave</u>		Former or usual residence.	
	15- Filed <u>191922</u> ROBERT R. KRAUTER, Registrar. Burial Permit <u>8</u>		19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. <u>David Gilger</u> <u>10/19</u> 19 <u>22</u> ADDRESS <u>118 N. Mt. Royal</u>	

MARGIN RESERVED FOR OFFICIAL USE. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

268458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD 73)

2-FULL NAME Sarah Stewart

(a) RESIDENCE NO. Unknown

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years 35 Months -- Days -- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

10 NAME OF FATHER Geo. Johnson

11 BIRTHPLACE OF FATHER (city or town) Charles Co. Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Pessie Blank

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed 191922 ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 15 19 22

17 I HEREBY CERTIFY, That I attended deceased from October 13, 1922 to October 15, 1922, that I last saw her alive on October 15, 1922, and that death occurred, on the date stated above, at 11:25 A.M.

The CAUSE OF DEATH* was as follows:

Epidemic encephalitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? CSF
(Signed) Chas. H. H. H. M. D.

10/10/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

Oct 19 19 22

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Angela Thompson* ST. *3* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *530 S. Caroline St.*
(Residence in Baltimore: No. *530 S. Caroline* St.; *129* yrs., *2* mos., *59* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*
4-COLOR OR RACE, *Colored*
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)
6-DATE OF BIRTH, *Oct 17, 1876*
(Month) (Day) (Year)
7-AGE, *46*
If LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Domestic*
(b) General nature of industry, business, or establishment in which employed (or employer), *Cooking*
9-BIRTHPLACE, (State or Country), *Virginia*
10-NAME OF FATHER, *Louis Price*
11-BIRTHPLACE OF FATHER (State or Country), *Ind*
12-MAIDEN NAME OF MOTHER, *Jane Lee*
13-BIRTHPLACE OF MOTHER (State or Country), *Virginia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Angela Thompson*
(Address) *530 S. Caroline St.*

15-*OCT 19 1922*
Filed *191* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 17, 1922*
(Month) (Day) (Year)
I HEREBY CERTIFY, That I attended deceased from *Oct 16* 19122 to *Oct 17* 19122 that I saw her alive on *Oct 16* 19122, and that death occurred, on the date stated above, at *11:45* m.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) *7* yrs. *7* mos. *7* ds.

CONTRIBUTORY (Secondary)
(Duration) *7* yrs. *7* mos. *7* ds.
(Signed) *John G. Edwards* M. D.
10-19, 19122 (Address) *704 W. Hampden St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death *7* yrs. *7* mos. *7* ds. In the State *7* yrs. *7* mos. *7* ds.

Where was disease contracted, if not at place of death?
Former or usual residence *129*

19-PLACE OF BURIAL OR REMOVAL, *St. Stephen's Cemetery* DATE OF BURIAL, *OCT 23, 1922*

20-UNDERTAKER, *Edmond Bryan* ADDRESS *631 Orleans St.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

268460 HEALTH DEPARTMENT—CITY OF BALTIMORE 268460

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St Agnes Hospital* St. *25* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *Bruppals 4 Y.* St.; yrs..... mos..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Caucasian* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH, *unknown* 1..... (Month) (Day) (Year)

7-AGE, *24* yrs..... mos..... ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *was in U.S. Navy* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Bruppals*

10-NAME OF FATHER, *Walter James*

11-BIRTHPLACE OF FATHER, (State or Country), *Bruppals*

12-MAIDEN NAME OF MOTHER, *unknown*

13-BIRTHPLACE OF MOTHER, (State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Clarence James*

(Address) *St Agnes Hospital*

15- Filed *OCT 19 1922* 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 12*, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Investigation* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Investigation* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Bullet wound - spine self inflicted suicide after accident wheel cut off both legs* (Duration) yrs..... mos..... ds.

CONTRIBUTORY (Secondary) (Duration) yrs..... mos..... ds.

(Signed) *James M. Fenton* M. D. (Coroner) *OCT 19 1922* (Address) *700 E Chase St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY. DATE OF BURIAL, *Oct 19*, 1922

20-UNDERTAKER, *Commissioner Health.* ADDRESS

Per. *Wm. F. Woodall*

THE MONITOR.

MARGIN RESERVED FOR BINDING PURPOSES. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

10.68461

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68461

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Howley

(a) RESIDENCE NO. Unknown

ST. 76 WARD

(If non-resident give city or town and State)

(Usual place of abode) Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Singles

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 23rd 1875

7 AGE Years 47 Months 0-- Days 24-- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

10 NAME OF FATHER James Howley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Maxwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Hospital Records, (Address) Municipal Hospital.

15 Filed Robert F. HARRIS, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 17 19 22

17 I HEREBY CERTIFY, That I attended deceased from August 26, 19 22, to October 17, 19 22, that I last saw him live on October 17, 19 22,

and that death occurred, on the date stated above, at 10:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Bronchopneumonia (Secondary)

(duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. J. H. Harris M. D.

10/18/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
BURIAL Calvary (New York City) DATE OF BURIAL Oct. 19th 22

20 UNDERTAKER Joseph B. Cook ADDRESS 1602 N. ...

D. 68462

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68462

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3036 Boston

ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Lemuk

(a) RESIDENCE. NO.

3036 Boston

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18, 1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Alex

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Ukraine

12 MAIDEN NAME OF MOTHER Czernoliska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Ukraine

14

Informant
(Address)Eva Lemuk. (Mother)
3036 Boston St

15

Filed

ROBERT P. HARRISON

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct. 18, 1922, to Oct. 19, 1922.

that I last saw him alive on Oct. 18, 1922.

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Prematurity at 27 wks

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs
(Signed) D. B. Brown, M. D.

1019, 1922 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem.

Oct 20, 1922

20 UNDERTAKER

ADDRESS

M. J. Sadowski

705 S. Ann St.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 19 1922

Burial Permit Clerk.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

2.68463

HEALTH DEPARTMENT—CITY OF BALTIMORE

2.68463

CERTIFICATE OF DEATH.

188-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No.)

2-FULL NAME

(Residence in Baltimore: No.)

REGISTERED NO. C

ST. WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed.....

101.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....
.....
..... (Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed)..... M. D.

(Coroner.)

1917. (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Stanislaus

Oct. 20, 1922

20-UNDERTAKER

ADDRESS

Kelly + Zich

403 S. Wofford

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.68464

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.68464

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 Light Street. St. 23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Charles Wesley Miller.

(Residence in Baltimore: No. 1114 Light St. St.; yrs. 39 -- 9 -- 29 -- mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH, December 19, 1882. 1. (Month) (Day) (Year)

7-AGE, 39 yrs. 9 mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Glass blower. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS. 10-NAME OF FATHER, Chales E. Miller. 11-BIRTHPLACE OF FATHER, (State or Country), Pa. Philadelphia. 12-MAIDEN NAME OF MOTHER, Louisa D. Thompson. 13-BIRTHPLACE OF MOTHER, (State or Country), Pa. Philadelphia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Edward R. Miller. (Address) 200 E. Gitting St.

15- Robert P. Harrison, Registrar. 16- 91322 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.) Oct. 19, 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Western Cemetery, Oct 21, 1922

20-UNDERTAKER, ADDRESS 1534

O. Schuman & Son, Hanover St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68465

D. 68465

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Robt Garrett Hospital for Children

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.)

27 N Carey ST., 18 WARD

2-FULL NAME

Ceil Harvey

(a) RESIDENCE NO.

951 Hollins

ST., WARD

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

white

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 29 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Francis D. Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Florence Michael

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14 Informant (Address)

Francis D. Harvey 951 Hollins St

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 14 1922, to October 22 1922, that I last saw him alive on October 22 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy?

no Physical Exam.

What test confirmed diagnosis?

I. M. Clift

M. D.

(Signed)

10/18/22 Address

27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill Cem

DATE OF BURIAL

Oct 20 1922

20 UNDERTAKER

C. Schloman Son

ADDRESS 139

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

10.68466

HEALTH DEPARTMENT—CITY OF BALTIMORE

129
D. 68466

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 Myrdeman St. 12 WARD)

2-FULL NAME

James Seimly

(a) RESIDENCE. NO.

924 Bolton

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Widowed

6 DATE OF BIRTH (month, day, and year)

Don't know 1876

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

46

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Janitor

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Maryland

10 NAME OF FATHER

John Seimly

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

md

12 MAIDEN NAME OF MOTHER

Dorcas Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

md

14

Informant
(Address)

Julia Weems
3405 Baskin St

15

Filed

Robert P. Harrison

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 30, 1922, to Oct. 18, 1922.

that I last saw him alive on Oct. 17, 1922.

and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)

None to my knowledge

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. K. Pettigrew, M. D.

, 19 (Address) 817 Hamilton Terr

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Best Gate Annapolis Co. Md.

DATE OF BURIAL

Oct 20 1922

20 UNDERTAKER

John H. Owens
(Annapolis Co. Md.)

ADDRESS

538 E. 1st St.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

10.68467 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68467
113
CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 439 N. Patterson Park ST., 6 WARD)

2. FULL NAME

Richard F. Davis

(a) RESIDENCE NO.

439 N. Patterson Park ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)
Length of residence in city or town where death occurred

— yrs. 5 mos. 15 ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)
Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Baby

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Baby.

6 DATE OF BIRTH (month, day, and year)

May 4 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Richard H. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Hilda M. Gayroux

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Joseph C. Chason 44507 Eastern Ave.

15

Filed

ROBERT E. HARTMAN, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 17, 1922, to Oct. 19, 1922.

that I last saw him alive on

Oct. 18, 1922.

and that death occurred, on the date stated above, at

10 a. m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

F. J. Hughes, M. D.

10.19.22 (Address)

1206 E. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery

Oct 19

20 UNDERTAKER

ADDRESS

Mrs. C. Miller

2334 Jefferson

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 68468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68468

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 241 J. Eden

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Theresa Hernandez

(a) RESIDENCE NO. 241 J. Eden

ST. 3 WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

2 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

J

4 COLOR OR RACE

N

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

9/28/21

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

Alfonso Hernandez

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Spain

12 MAIDEN NAME OF MOTHER

Rosa Delgado

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Spain

14

Informant (Address)

Dr. Angela Grass 221 N. 5th St.

15

Filed

19

Robert P. ... Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/18/22 19

17

I HEREBY CERTIFY, That I attended deceased from

10/16/22 to 10/18/22

that I last saw her alive on 10/18/22 19

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

(Pneumonia)

(duration) 2 days mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Final puncture 10/18/22

(Signed) ... M. D.

10/18/22 (Address) 912 W. L. ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Mr. C. Miller

DATE OF BURIAL

10/20/22 19

ADDRESS

2534

Jefferson St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

268469 HEALTH DEPARTMENT—CITY OF BALTIMORE 268469

1-PLACE OF DEATH Bay View
City of BALTIMORE: (No. 17 St. 17 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Mabel Cooke
(Residence in Baltimore: No. 1210 Division St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE Black 5-Single, Married, Widowed, or Divorced, (Write the word.) Married
6-DATE OF BIRTH May 11 1896 (Month) (Day) (Year)
7-AGE 26 yrs. 5 mos. 6 ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work Domestic (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country) Balto
10-NAME OF FATHER S. Charles Carter
11-BIRTHPLACE OF FATHER Va
12-MAIDEN NAME OF MOTHER Lily Steward
13-BIRTHPLACE OF MOTHER Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Esther L. Carter
(Address) 1131 W. Saratoga St.

15- OCT 20 1922 ROBERT R. KRAUTER, Registrar.
Filed 1922 Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 17 1922 (Month) (Day) (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy, or inquest, at thereon and from the evidence obtained by said Autopsy (Inquest, at topsy or inquiry.) and that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

General Septic Poisoning
Gangrene Uterus

(Duration) yrs. mos. ds.
CONTRIBUTORS Self performed
(Secondary) Abortion
(Duration) yrs. mos. ds.
(Signed) Thos. B. Horton, M. D.
(Address) Curtis Bay

*State the Disease Causing Death or in Deaths from Violent Causes, State (1) Means of Injury (2) Cause of Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Mt. Zion Cemetery Oct 20, 1922
20-UNDERTAKER, ADDRESS 303 James A. Hennick Pressman

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 St. 33rd ST. 13 WARD)

2-FULL NAME Edward C. Curran

(a) RESIDENCE NO. 818 St. 33rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Ed Middleton Curran

6 DATE OF BIRTH (month, day, and year) April 19/1858

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 64 5 29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stock Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

10 NAME OF FATHER Thomas Curran

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Katherine Corrigan

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. Ed Middleton Curran (Address) 818 St. 33rd

15 Filed OCT 20 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1922

17 I HEREBY CERTIFY, That I attended deceased from

June 15, 1921, to October 18, 1922.

that I last saw him alive on October 18, 1922.

and that death occurred, on the date stated above, at 11:05 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. 16 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davis, M. D.

10-18-22 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

10/21 1922

20 UNDERTAKER

ADDRESS

Stalter Davis

3307 Paine St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68471 HEALTH DEPARTMENT—CITY OF BALTIMORE 68471

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. *Hebrew Hosp.* St. *6* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Joseph Mack (Max)*
(Residence in Baltimore: No. *1715 E. Taunton Ave.* St.; yrs. *40* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>White</i>	5- <i>Married</i> Single, Married, Widowed, or Divorced, (Write the word.)
6-DATE OF BIRTH, <i>unknown</i> 1. (Month) (Day) (Year)		
7-AGE, <i>56</i> yrs. mos. ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Laborer</i> (b) General nature of industry, business, or establishment in which employed (or employer), <i>Balls City, Mass.</i>		
9-BIRTHPLACE, (State or Country), <i>Russia</i>		
PARENTS.	10-NAME OF FATHER, <i>Benj. H. Mack</i>	
	11-BIRTHPLACE OF FATHER, (State or Country), <i>Russia</i>	
	12-MAIDEN NAME OF MOTHER, <i>unknown</i>	
	13-BIRTHPLACE OF MOTHER, (State or Country), <i>Russia</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Julius Mack (Son)*
(Address) *1715 E. Taunton Ave.*

15-*OCT 20 1922* ROBERT R. MAUTER, Registrar.
Filed 1922. *Burial Permits Clerk*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 19* 192*2*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.
The CAUSE OF DEATH* was as follows:
Cardiac failure due to chronic Nephritis
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *Nephritis for several yrs.* (Duration) yrs. mos. ds.
(Signed) *J. H. Waller* M. D. (Coroner)
10-20 192*2*. (Address) *508 E. North Ave.*
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence,
19-PLACE OF BURIAL OR REMOVAL, *Hebrew Herring Bur.* DATE OF BURIAL, *Oct 20* 192*2*
20-UNDERTAKER, *May Lervin* ADDRESS *1087 E. Balto St.*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

268472 HEALTH DEPARTMENT—CITY OF BALTIMORE 268472

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 1829 Orleans St., 6 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Chew
(Residence in Baltimore: No. 1829 Orleans St.; yrs. mos. ds.)

Registered No. C.

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, Female	4-COLOR OR RACE, Colored	5-Single, Married, Widowed, or Divorced, widowed (Write the word.)	16-DATE OF DEATH, Oct. 18, 1922 (Month) (Day) (Year)	
6-DATE OF BIRTH, (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.	
7-AGE, 64 yrs. 12 mos. ds. If LESS than 1 day, hrs. or min.			The CAUSE OF DEATH* was as follows: Ac Gastroenteritis	
8-OCCUPATION: (a) Trade, profession, or particular kind of work, House work (b) General nature of industry, business, or establishment in which employed (or employer), 670			(Duration) yrs. mos. ds.	
9-BIRTHPLACE, (State or Country), Maryland			CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.	
PARENTS.	10-NAME OF FATHER, James Chew	11-BIRTHPLACE OF FATHER, (State or Country), Maryland	(Signed) (Coroner.)	
	12-MAIDEN NAME OF MOTHER, Carrie Chew	13-BIRTHPLACE OF MOTHER, (State or Country), Maryland	192 (Address)	
	14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Annie Hutchins (Address) 1829 Orleans St.		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
	15- Filed OCT 20 1922 REGISTRAR		18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?	
19-PLACE OF BURIAL OR REMOVAL, Chase, Maryland			DATE OF BURIAL, Oct. 22, 1922	
20-UNDERTAKER, Milton Davis 315 N Eden St			ADDRESS	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

268473 HEALTH DEPARTMENT—CITY OF BALTIMORE. 268473
71-001
1-PLACE OF DEATH
City of BALTIMORE: (No. *Johns Hopkins Hosp 5*) Ward (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Charles Jones*
(Residence in Baltimore: No. *1407 E. Fennimore St.*; yrs. *6* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.
3-SEX *Male* 4-COLOR OR RACE *Black* 5-*Single*
6-DATE OF BIRTH *Jan 1 1922*
7-AGE *6* yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Child*
(b) General nature of industry, business, or establishment in which employed (or employer) *Child*
9-BIRTHPLACE, (State or Country), *Balto Md.*
10-NAME OF FATHER *Chas Jones*
11-BIRTHPLACE OF FATHER, (State or Country), *Md.*
12-MAIDEN NAME OF MOTHER, *Hattie Kelly*
13-BIRTHPLACE OF MOTHER, (State or Country), *Balto Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Hattie Jones*
(Address) *1407 E. Fennimore St.*

15-*OCT 20 1922* Filed *1922* *ROBERT L. KAMSTER* Registrar.

CORONER'S CERTIFICATE OF DEATH.
16-DATE OF DEATH, *Oct 19 1922*
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* thereon and from the evidence obtained by said *inquest* find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Streptococcus Meningitis
PM at Hospital
CONTRIBUTORY (Secondary) *10-20-1922*
(Signed) *J. J. Potter* M. D. (Coroner.)
18-LENGTH OF RESIDENCE (For Hospitals, institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Laurel Cemetery Oct 21 1922*
20-UNDERTAKER, ADDRESS *Milton Davis 315 N. Cal.*

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 W. Ostend st

ST. 23 WARD)

2-FULL NAME Lydia A. Hill

(a) RESIDENCE No. 120 W. Ostend St.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of Edwin C. Hill
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 30 1845

7 AGE Years Months Days If LESS than 1 day, hrs or min.
76 10 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co. Md.
(State or country)

10 NAME OF FATHER John Higdon

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Nancy Taylor

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Edwin C. Hill
(Address) 120 W. Ostend St.

15 Filed 10/20/22 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 17 19 22, to Oct 18 19 22.

that I last saw her alive on Oct 18 19 22.

and that death occurred, on the date stated above, at 5-0 m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY Menia + pulmonary Edema (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinary Multiple M. D.

(Signed) 10/19/22 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL 10/21 19 22

20 UNDERTAKER

J. Geo McCully 130 E. Fort

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1627 Miller* St.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Life 1627 Miller St.*St.; yrs., *31* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*Colored*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Jan 30, 1892
(Month) (Day) (Year)

7-AGE,

31

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

House Wife
House Wife

9-BIRTHPLACE,

(State or Country),

Baltimore

10-NAME OF FATHER,

Samuel Brown

11-BIRTHPLACE OF FATHER

(State or Country),

Bonny Balt

12-MAIDEN NAME OF MOTHER

Carrie Gibson

13-BIRTHPLACE OF MOTHER

(State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

H. Benjamin Bunday

(Address)

1627 Miller St.

15-

Filed

191

ROBERT R. KNAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Aug 15, 1922, to Oct 13, 1922,*that I saw him alive on *Oct 17, 1922,*and that death occurred, on the date stated above, at *4:45 A.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(Duration) *1* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

(Duration) *None known*

(Signed)

Chas. J. Keller M. D.
Oct 18, 1922 (Address) *222 W. Monument St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

Laural Cemetery

DATE OF BURIAL,

Oct 22, 1922

20-UNDERTAKER

Mrs. Robert A. Elliott Ashland

ADDRESS

*1725*PLAINLY, WITH UNFADEING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 St Ann Ave. ST.: 9 WARD)

2-FULL NAME

Josephine Vogt.

(a) RESIDENCE. NO.

627 St Ann Ave. ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give name and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 1883

7 AGE Years 38 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Beth

10 NAME OF FATHER John Winter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Beth

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Beth

14 Informant Rev N West (Address) 627 St Ann Ave

15 Filed Oct 20 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19. 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to Oct 19, 1922, that I last saw her alive on Oct. 19., 1922.

and that death occurred, on the date stated above, at 10 15 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Gen. Sympth & Reiss Ex.

(Signed) John Starkman, M. D.

10/20, 1922 (Address) 888 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Paradise Tension Oct 22. 1922

20 UNDERTAKER ADDRESS John Child 1200 N Lombard

THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Q 68477

HEALTH DEPARTMENT—CITY OF BALTIMORE

Q 68477

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *165* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Jenna Wehr*
(Residence in Baltimore: No. *2014 E. Eppinger* St.; yrs. *44* mos. *21* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH, *Oct 28* 18*77*
(Month) (Day) (Year)

7-AGE, *44* yrs. *11* mos. *21* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Electrician*
(b) General nature of industry, business, or establishment in which employed (or employer) *Int'l Ry.*

9-BIRTHPLACE, (State or Country), *Balt. Md*

10-NAME OF FATHER, *Francis Wehr*

11-BIRTHPLACE OF FATHER, (State or Country), *Balt*

12-MAIDEN NAME OF MOTHER, *Lora Meyer*

13-BIRTHPLACE OF MOTHER, (State or Country), *Balt*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jenna Wehr*

(Address) *2014 E. Eppinger*

15- *OCT 20 1922* *ROBERT R. KRAUTER,*
Filed (Regist.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 18* 192*2*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.)
And that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Broken Mercurial Thermometer
(Suicide - Suspended)
(P.M. as Hospital)
(Duration) ... yrs. ... mos. *19* ds.

CONTRIBUTORY (Secondary) *Broken Mercurial Thermometer*
(Duration) ... yrs. ... mos. *3* ds.
(Signed) *J. H. Pater* M. D.
(Coroner)
10-19 192*2* (Address) *508 E. Pratt*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death... yrs. ... mos. ... ds. In the State... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Schwartz Cem.* DATE OF BURIAL, *Oct. 21, 1922*

20-UNDERTAKER, *Philip Hennig* ADDRESS *2016 Orleans St.*

RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *University Hospital*
CITY OF BALTIMORE: No. *Cor. Lombard & Greene.* ST. *S.* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2-FULL NAME *Roy J. Steigewold. (Steigermwald)*
(a) RESIDENCE. No. *1904 Orleans.* ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred *19* yrs. *11* mos. *23* ds. (If nonresident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male.* 4 COLOR OR RACE *white.* (Single, Married, Widowed, or Divorced (write the word)) *single.*

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1902. Oct 24*

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
19 years. *11* *23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Stenographer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer *Columbia Graphophone Co.*

9 BIRTHPLACE (city or town) (State or country) *Maryland.*

10 NAME OF FATHER *Adam Steigewold*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Pennsylvania*

12 MAIDEN NAME OF MOTHER *Betha Cress*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland.*

14 Informant *Hospital Records.*
(Address) *Cor. Lombard & Greene Sts.*

15 Filed *307-20-1922* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 17.* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 30,* 19*22,* to *October 17,* 19*22.*
that I last saw him alive on *October 17,* 19*22.*
and that death occurred, on the date stated above, at *7:30 A.* m.

The CAUSE OF DEATH* was as follows:

Pneumothorax - Left side.

(duration) yrs. *one* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Oct 2-1922*

Was there an autopsy? *no.*

What test confirmed diagnosis? *Clinical Findings*
(Signed) *Dr. L. J. Brumback,* M. D.
. 19 (Address) *University Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

W. T. Carmel Cem. *Oct 20* 19*22*

20 BURIAL ADDRESS

Philip Herwig *2016 Orleans*

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Probably Tubercular

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

968479 HEALTH DEPARTMENT—CITY OF BALTIMORE 968479
CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1244 Orleans ST. 5 WARD)

2-FULL NAME Marguerite A. Gender

(a) RESIDENCE NO. 1244 Orleans ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

John Gender.

6 DATE OF BIRTH (month, day, and year) Sept 2-1859

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

63 1 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Chas Heilman

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mr John Gender (Address) 1244 Orleans

15 Filed OCT 20 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1922, to Oct 15, 1922, that I last saw him alive on Oct 17, 1922, and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows: Arterio Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Leach M. D. 10/19/22 (Address) 418 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore Cemetery Oct 20 1922

20 UNDERTAKER

ADDRESS

John Illerich 2008 Orleans

RESERVED FOR BINDING
N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

158967

868480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

JOHNS HOPKINS HOSPITAL ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harry Meade

(a) RESIDENCE NO.

Monkton, Maryland

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Unknown

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of Mary Meade (wife)

6 DATE OF BIRTH (month, day, and year)

June 10, 1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Cal.

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

ROBERT R. MAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 9, 1922, to Oct 19, 1922,

that I last saw him alive on Oct 19, 1922,

and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Endocarditis

(duration) 3 yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

Pulmonary Infarct

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. W. Cunningham, M. D.

10/19/1922 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Good Will Church Cem Oct 21, 1922

20 UNDERTAKER

ADDRESS

E. J. Kurtz & Son

Parrettville Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Druid Hill Ave. St. 14 WARD)

2-FULL NAME

(Residence in Baltimore: No. 1421 Druid Hill Ave. No. 63 yrs. 63 mos. 63 ds.)REGISTERED NO. C 90 D 68481

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Feb. 2, 1859
(Month) (Day) (Year)

7-AGE,

63 yrs. 8 mos. 16 ds.

If LESS than 1 day,
....hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Housewife
At home9-BIRTHPLACE,
(State or Country),

W. Va.

PARENTS.

10-NAME OF FATHER,

John Jordan

11-BIRTHPLACE OF FATHER
(State or Country),

W. Va.

12-MAIDEN NAME OF MOTHER

Blanche Williams

13-BIRTHPLACE OF MOTHER
(State or Country),

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche Kent Harrod(Address) 1421 Druid Hill Ave.

15-

Filed OCT 20 1922 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 10, 1922, to Oct. 18, 1922

that I saw him alive on Oct. 15, 1922

and that death occurred, on the date stated above, at 3:50 p. m.

The CAUSE OF DEATH* was as follows:

Initial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Pneumonia (Duration) yrs. mos. ds.

(Signed) W. E. Carr M. D.1922 (Address) 513 N. E. St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn Cemetery

DATE OF BURIAL,

Oct. 21, 1922

20-UNDERTAKER

Jno M. Johnson

ADDRESS

1234 Eling St.

BINDER

THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 18, 1922*

I HEREBY CERTIFY That I attended deceased from
October 9 - 19 18 to October 18 19 22
that I last saw him alive on October 18 19 22
and that death occurred, on the date stated above, at 10.45 P.m.

The CAUSE OF DEATH* was as follows:

apoplexy
Chronic Bright Disease +
complication Disease

CONTRIBUTORY (Secondary) *Bright Disease + Complications*
 (duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? _____
(Signed) W. L. Wynn, M.D.

10-19, 1922 (Address) *708 Enson rd*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL
--	----------------

10/30/53

20 UNDERTAKER ADDRESS 570

15 Filed Oct 20, 1922 *GL*

Registrar

MARGIN RESERVED FOR BINDING
N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

268483 HEALTH DEPARTMENT—CITY OF BALTIMORE
268483
38 268483
268483

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 365 St. Preston 17 ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Gale
(a) RESIDENCE NO. 365 St. Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 9 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Cal. 5 Single, Married, Widowed, or Divorced, (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/5/1912
7 AGE Years 9 Months 10 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED School
(a) Trade, profession or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

10 NAME OF FATHER Frank Gale

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Mary Gale

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant (Address) Geo. Matuz

15 Filed 3 65 St. Preston 17 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/16 19 22

17 I HEREBY CERTIFY That I attended deceased from July 10, 19 22 to Oct. 16, 19 22 that I last saw him alive on Oct. 16, 19 22 and that death occurred, on the date stated above, at 10:20 P. M.
The CAUSE OF DEATH* was as follows:

Paralysis
(duration) yrs. mos. 10 ds.
CONTRIBUTORY Cerebral hemorrhage (Secondary) (duration) yrs. 4 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical (Signed) John H. Thompson M. D.

10/17, 19 22 (Address) 1019 Davis Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- BURIAL DATE OF BURIAL

20 UNDERTAKER Address 378

Funeral Home

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1560 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

36 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (Write the word)

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from 10-14, 1922, to 10-17, 1922.

that I last saw him alive on 10-12, 1922.

and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68485

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. South Baltimore General Hospital. Ward)

2-FULL NAME. Luther Stanley.(C):

(Residence in Baltimore: No. 501 W. Preston St. St.; yrs., mos., ds.)

Registered No. 199 68485

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Do not know. (Month) (Day) (Year)

7-AGE, 30 yrs., mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Dorchester Co. Md.

PARENTS.

10-NAME OF FATHER, Adam Stanley.(C).

11-BIRTHPLACE OF FATHER, (State or Country), Dorchester Co. Md.

12-MAIDEN NAME OF MOTHER, Hattie Thompson.(C).

13-BIRTHPLACE OF MOTHER, (State or Country), Dorchester Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Adam Stanley.(C).(father). (Address) 501 W. Preston St.

15- Filed OCT 20 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 17th, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above. The CAUSE OF DEATH* was as follows: Hemorrhage, severance of left femoral artery. Automobile collision. Homicide, (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) (Duration) yrs., mos., ds. (Signature) Otto M. Remhardt M. D. (Coroner.) Oct. 19 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs., mos., ds. In the State yrs., mos., ds. Where was disease contracted, if not at place of death Accident Hanover & Randall sts. Oct. 17, 1922. Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, Cambridge Md DATE OF BURIAL, Oct 20, 1922

20-UNDERTAKER, John H. Foaden ADDRESS, 142 W. Hill St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 E Fort Ave WARD)

2-FULL NAME Elizabeth Moore

(a) RESIDENCE NO. 506 E Fort Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of Brucella Moore (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6 1841

7 AGE Years 81 Months 9 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER George Robinson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Babara Ann

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Eunice Luthers (Address) 506 E Fort Ave

15 Filed 201922 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 17 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1922, to Oct 17, 1922, that I last saw her live on Oct 17, 1922 and that death occurred, on the date stated above, at 8:15 P.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

CONTRIBUTORY (duration) yrs. mos. ds. Cerebral haemorrhage (Secondary) (duration) yrs. mos. ds. 2 mos. 7 ds.

18 Where was disease contracted Home if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs (Signed) Sidney H. Street M. D.

(Address) 405 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Cross Street Cemetery 10/19/22

20 UNDERTAKER ADDRESS

Jno J. Zahner & Sons 1318 Light

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE	
268487	
1-PLACE OF DEATH	
City of BALTIMORE: (No. <i>St. Joseph Hospital</i> St. <i>Ward</i>)	
2-FULL NAME <i>Henry Hogan</i>	
(Residence in Baltimore: No. <i>1421 St. Matthews</i> St.; yrs. <i>30</i> mos. ds.)	
3-SEX <i>Male</i>	
4-COLOR OR RACE <i>Colored</i>	
5-Single, Married, Widowed, or Divorced, (Write the word.) <i>Married</i>	
6-DATE OF BIRTH	
7-AGE <i>48</i> yrs. mos. ds.	
8-OCCUPATION: (a) Trade, profession, or particular kind of work <i>Labor</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>040</i>	
9-BIRTHPLACE (State or Country) <i>North Carolina</i>	
10-NAME OF FATHER <i>Charles Hogan</i>	
11-BIRTHPLACE OF FATHER (State or Country) <i>North Carolina</i>	
12-MAIDEN NAME OF MOTHER <i>Unknown</i>	
13-BIRTHPLACE OF MOTHER (State or Country) <i>North Carolina</i>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Amelia Hogan</i> (Address) <i>1421 St. Matthews St.</i>	
15- Filed <i>Oct 20 1922</i> Registrar. <i>JS</i>	
CORONER'S CERTIFICATE OF DEATH.	
16-DATE OF DEATH <i>Oct 18 1922</i> (Month) (Day) (Year)	
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows: <i>Rupture of the Heart</i> (Duration) yrs. mos. ds. <i>1 day</i>	
CONTRIBUTORY (Secondary) <i>Hypertension</i> (Duration) yrs. mos. ds. <i>1 day</i>	
(Signed) <i>Geo. Clinton Williams</i> M. D. (Coroner) <i>W. H. Brown</i> 1922 (Address) <i>1421 St. Matthews St.</i>	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?	
Former or usual residence	
19-PLACE OF BURIAL OR REMOVAL <i>Resbury</i> DATE OF BURIAL <i>Oct 21 1922</i>	
20-UNDERTAKER <i>John W. Henderson</i> ADDRESS <i>1502 E. Monument</i>	

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 68488
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 S. Fourth ST., WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. Single, Married, Widowed, Divorced, (write the word)

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.

8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (city or town)
(State or country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (city or town)
(State or country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (month, day, and year)

17. I HEREBY CERTIFY, That I attended deceased from
Oct 19, 1922, to Oct 20, 1922

that I last saw him alive on Oct 20, 1922

and that death occurred, on the date stated above, at 12:45 A.M.

The CAUSE OF DEATH* was as follows:

Prismatic BIRTH

CONTRIBUTORY
(Secondary)

18. Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Will J. Ryan, M. D.
Oct 20, 1922, 801, a return

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20. UNDERTAKER

Stephen J. Galkowski

MAINTAIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

902
D 68489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68489

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 4768 Pinlick Road ST. 27 WARD)

2 FULL NAME Henry F. Wildenforst

(Residence in Baltimore: No. 4768 Pinlick Road St. 46 yrs. 4 mos. 12 ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6 DATE OF BIRTH June 7, 1876 (Month) (Day) (Year)

7 AGE 46 yrs. 4 mos. 12 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work Salesman 66 (b) General nature of industry, business, or establishment in which employed (or employer) Atlantic Process Co

9 BIRTHPLACE (State or country) Baltimore Md

10 NAME OF FATHER Louis R. Wildenforst

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Goerring

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Ethel Edna Wildenforst

(Address) 4768 Pinlick Road

15 OCT 20 1922 ROBERT R. KRAUTER

Filed 191 Burial Permit Blank REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 19, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from Oct 19, 1922, to Oct 19, 1922, that I saw him alive on Oct 18, 1922, and that death occurred, on the date stated above, at 3 A. M. The CAUSE OF DEATH* was as follows:

chronic valvular Heart Disease

(Duration) 2 yrs. mos. ds

Contributory (SECONDARY) (Duration) yrs. mos. ds

(Signed) G. W. Westhoff M. D. 10/19, 1922 (Address) 2020 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Baltimore Cemetery DATE OF BURIAL Oct 21, 1922

20 UNDERTAKER John F. Denny ADDRESS 715 Light S

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

268490
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 S. Fremont Ave ST. 22 WARD)

2-FULL NAME Frederick Hardy

(a) RESIDENCE. No. 509 S. Fremont Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. If of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Mayland

10 NAME OF FATHER Frederick Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ohio

12 MAIDEN NAME OF MOTHER Elizabeth Farrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Frederick Hardy 509 S. Fremont Ave

15

Filed

19

Registrar

OCT 20 1922

113
REGISTERED No. 268490

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

22

WARD.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 20 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 19 1922, to Oct 20 1922.

that I last saw him alive on Oct 19 1922.

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Staining

(Signed)

W. M. D.

Address 729 Trach. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem.

10/22/22

20 UNDERTAKER

ADDRESS

George Farley Fulton & Fayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

20.68491 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68491
CERTIFICATE OF DEATH. 111-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 737 W. Franklin ST.: 17 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 737 W. Franklin ST., WARD.

(Usual place of abode)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14, 1884

7 AGE Years 68 Months 6 Days 4 If LESS than 1 day, hrs. or min.

5 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Joseph Wittkowsky (Address) 737 W. Franklin St.

15 Filed ROBERT A. HAYTADON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 24, 1922, to Oct 17, 1922, that I last saw him alive on Oct 17, 1922, and that death occurred, on the date stated above, at 5:15 a. m.

The CAUSE OF DEATH* was as follows:

Gastritis (Gastric Ulcer)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Smith, M. D.

, 19 (Address) 109 W. Lu. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Oct 21 1922

20 UNDERTAKER ADDRESS

Harry H. Witzke 15314 Lombard

dl. 68492 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68492

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Robt Garrett Hospital for Children* REGISTERED NO. *113*
 CITY OF BALTIMORE: (No. *27 N. Carey* ST., *12* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
 2-FULL NAME *Edna Stidham*
 (a) RESIDENCE NO. *2617 Hampden Ave* ST., WARD
 (Usual place of abode) (If non-resident give city or town and State)
 Length of residence in city or town where death occurred yrs. *8* mos. *16* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*
 6a If married, widowed, or divorced HUSBAND of (or) WIFE of
 6 DATE OF BIRTH (month, day, and year) *Feb 3 1922*
 7 AGE Years Months Days If LESS than 1 day, hrs. or min.
8 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant
 (Address)

15

Filed

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 19 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 2*, 19*22*, to *Oct 19*, 19*22*, that I last saw her alive on *Oct 19*, 19*22*, and that death occurred, on the date stated above, at *2:30 P.* m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary)

Intestinal Indigestion & Diarrhoea (duration) yrs. mos. *3* ds. yrs. *1* mos. *14* ds.

18 Where was disease contracted if not at place of death? *unknown*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Physical Exam*

(Signed)

J. W. Clark, M. D. 10/19, 1922 (Address) *27 N. Carey St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Marys Hospital Oct 21 1922

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 20 1922

D. 68493

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68493

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 St. Paul ST.: 12 WARD)

2-FULL NAME

Janet Blair Rivers

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

2414 St Paul

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed,

or Divorced (write the word)
married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Arthur D. Rivers

6 DATE OF BIRTH (month, day, and year)

12/12/1859

7 AGE

63

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

none

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Va.

10 NAME OF FATHER

Cyus Bess

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Va.

12 MAIDEN NAME OF MOTHER

Clara M. Rivers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Va.

14

Informant
(Address)Arthur D. Rivers
2414 St. Paul St

15

Filed

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 9 1922, to Oct 20 1922.

that I last saw her alive on Oct 19 1922.

and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease.

(duration) yrs. 11 mos. ds.

CONTRIBUTORY Thrombosis of l. femoral artery
(Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted

if not at place of death?

no

Did an operation precede death?

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

H. J. Watson

M.D.

2128 St Paul St Balit

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park

Oct. 21, 1922

20 UNDERTAKER

ADDRESS

George J. Smith.

20025
Sydney

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

10.68494 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68494
CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1047 Mawale ST.; 16 WARD)
2-FULL NAME St. Edgar Jensen
(Residence in Baltimore: No. 1047 Mawale St.; 10 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.
4-COLOR OR RACE. A.
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
6-DATE OF BIRTH. March 24, 1858
7-AGE. 64 yrs. mos. ds.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. Stone
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Prigence

10-NAME OF FATHER, Don't Know
11-BIRTHPLACE OF FATHER (State or Country), Don't Know
12-MAIDEN NAME OF MOTHER, Don't Know
13-BIRTHPLACE OF MOTHER (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Stathering Jensen
(Address) 1047 Mawale St.

15-
Filed. Robert H. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 18, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 16 1922, to Oct 18 1922, that I saw him alive on Oct 18 1922, and that death occurred, on the date stated above, at 11:50 m. The CAUSE OF DEATH* was as follows:

Central Hemorrhage
(Duration) 4 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) uraemia

(Duration) yrs. mos. ds.
(Signed) William F. Stillman M. D.
Oct 19, 1922 (Address) 1227 W. Lafayette Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mount Ridge DATE OF BURIAL, Oct 21, 1922

20-UNDERTAKER, George J. Smith ADDRESS 100084 Fayette St

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68495

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Albin Hotel

CITY OF BALTIMORE: NO.

Richmond & Cathedral

ST.:

WARD)

2-FULL NAME

Louisa B. Latrobe

(a) RESIDENCE. NO.

Richmond & Cathedral

ST.:

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

(or) WIFE of

Late Charles H. Latrobe

6 DATE OF BIRTH (month, day, and year)

August 4th 1839

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

83

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Royal T. Church

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mass

12 MAIDEN NAME OF MOTHER

Ann Alden

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mass

14 Informant

S. S. McKim

(Address)

Albin Hotel

15 Filed

1900-10-21

Registrar

21 UNDERTAKER

Henry J. Jenkins & Co

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 20

1922

17 I HEREBY CERTIFY, That I attended deceased from

July

1922, to

Oct 14th

1922,

that I last saw her alive on

Oct 14th

1922,

and that death occurred, on the date stated above, at

9 P. m.

The CAUSE OF DEATH* was as follows:

Altimodschosis Myocarditis

all 3

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Pneumonia

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. B. Hambley, M. D.

, 19 (Address) 24 N. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cem

Oct 21 1922

21 UNDERTAKER

Henry J. Jenkins & Co

ADDRESS

24 N. Biddle St.

MARGIN RESERVED FOR BINDING

EVERY ITEM OF INFORMATION PLACED IN THIS IS A PERMANENT RECORD. PHYSICIANS SHOULD STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificate 3.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be properly classified. See instructions on back of certificate 3.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.68496

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68496

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 631 W. Lexington Cor Arch. St., 4 Ward)

Registered No. C.....

2-FULL NAME

Katherine Mainberg

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 631 W. Lexington Cor Arch. St.; yrs., 40 mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Don't Know 1 (Month) (Day) (Year)

7-AGE, 80 yrs., mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Mainberg

(Address) 621 W. Lexington St.

15-

Robert P. Harrison,

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to her death on the day stated above. The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) Don't Know mos., ds.

CONTRIBUTORY (Secondary) Don't Know

(Duration) yrs., mos., ds.

(Signed) H. K. Gorman, M. D. (Coroner.)

10121, 1922 (Address) 117 W. Parsonage St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Park Ch. Oct 21, 1922

20-UNDERTAKER, ADDRESS

Geo Lembackes 647 W. 1st St.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

20.68497 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68497
129
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Morrow Hospital ST., 4 WARD)

2-FULL NAME

Charles E. Adams

(a) RESIDENCE NO.

102 Market Place ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred

unknown yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

unknown

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5-5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

Merchant Seaman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Delaware

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

unknown

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

unknown

14

Informant (Address)

Patients' History Morrow Hosp

15

Robert P. Harrison,

City

19

Registrar

Barial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/19/22

17

I HEREBY CERTIFY, That I attended deceased from 6/5, 1922, to 10/19, 1922,

that I last saw him alive on 10/19, 1922,

and that death occurred, on the date stated above, at 11:55 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 2 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary)

Chronic nephritis

(duration) 1 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) P. E. Schools, M. D.

10/20/22 (Address) Morrow Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Trinity Cemetery

DATE OF BURIAL

10/21 1922

20 UNDERTAKER

A. Linnson & Son E. Balto St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68498 HEALTH DEPARTMENT—CITY OF BALTIMORE
44 68498
1-PLACE OF DEATH Bay View
City of BALTIMORE: (No. 3 St. 3 Ward)
2-FULL NAME Joseph Pakalnis
(Residence in Baltimore: No. 28 So. Albemarle St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.
3-SEX male
4-COLOR OR RACE white
5-Single, Married, Widowed, or Divorced. (Write the word.) Single
6-DATE OF BIRTH Unknown
7-AGE About 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work Junk Dealer
(b) General nature of industry, business, or establishment which employed (or employer).
9-BIRTHPLACE (State or Country) Lithuania
10-NAME OF FATHER Unknown
11-BIRTHPLACE OF FATHER (State or Country) Lithuania
12-MAIDEN NAME OF MOTHER Unknown
13-BIRTHPLACE OF MOTHER (State or Country) Lithuania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. Pucinas
(Address) 429 So. Park St

15- Robert P. Harrison, Registrar.
1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH
16-DATE OF DEATH Oct 18 1922
17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by Inquest find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Carcinoma Stomach
Unknown
CONTRIBUTORY (Secondary) Unknown
(Signed) J. B. Fortson M. D.
Coroner.
1922 (Address) Curtis Bay
*State the Disease Causing Death, or, in months from violent Causes, state (1) Means of Injury, and (2) whether Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
St. Stanislaus Oct 21, 1922
20-UNDERTAKER ADDRESS
John G. Williams 425 S. Park St

MARGIN RESERVED FOR BINDING

BALTIMORE
✓ 36-005 D 68499
REGISTERED NO.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No 729 W. Mulberry st.

ST. WARD

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred **Life** yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 18, 1922

17

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

I HEREBY CERTIFY, That I attended deceased from
Oct. 7 1921 to Oct. 18 1922

that I last saw him alive on Oct. 18, 1922

and that death occurred, on the date stated above, at 7.15 p.m.

The CAUSE OF DEATH* was as follows:

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... **Laborer**

(b) General nature of industry, business, or establishment in which employed (or employer)	Unknown
--	---------

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Fred Bailey

II BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Salina Reed

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Hospital Records

15
Filed 1922 19
Burial Permit Clerk

Registrar

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY Retro-peritoneal tubercu-
(Secondary)
lous Adnitis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Link 20: 2m

Did an operation precede death? 110 Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Trichin sporum
(Signed) Francis L. Sabaghsca M. D.

10-19-22 (Address) Municipal Bldg. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 970

MARGIN RESERVED FOR BINDING
B. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D68500

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D68500

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1422 Ward*)

ST.: *21* WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ruth White

(a) RESIDENCE. NO. *1422 Ward* ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. *1* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Col* 5 Single, Married, Widowed, or Divorced (write the word) *-*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 15/22*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balt City*

10 NAME OF FATHER *Edward White*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Unknown*

12 MOTHER'S NAME OF MOTHER *White*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *MD*

14 Informant *Alain E. Eason* (Address) *216 E. ...*

15 Filed *19* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 18 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 15*, 1922, to *Oct 18*, 1922, that I last saw him alive on *Oct 18*, 1922, and that death occurred, on the date stated above, at *8 P.* m.

The CAUSE OF DEATH* was as follows: *Ac. Enteritis*

(duration) yrs. mos. ds. CONTRIBUTORY (Secondary) *Exhaustion* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *no*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Physical Exam.*

(Signed) *Wm. C. Longmire*, M. D. 1021, 1922 (Address) *176 Edmondson*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *not known* DATE OF BURIAL *Oct 21 1922*

20 UNDERTAKER *David ...* ADDRESS *916*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68501

D. 68501

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

St. Joseph's Hospital

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Thomas Milanicz
1703 Aliceanna

(Residence in Baltimore: No.

St.: 16 yrs., 10 mos., 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

white

5-SINGLE, ☒ MARRIED, ☐ WIDOWED, ☐ OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

December 15, 1906
(Month) (Day) (Year)

7-AGE,

16 10 5
yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country),

Baltimore, Md.

10-NAME OF FATHER,

Robert Milanicz

11-BIRTHPLACE OF FATHER (State or Country),

Poland

12-MAIDEN NAME OF MOTHER

Agnes Gluska

13-BIRTHPLACE OF MOTHER (State or Country),

Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Robert P. Harrison

(Address)

1803 Aliceanna St.

15-

Robert P. Harrison,

Filed 11-19-22

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 20, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1922, to Oct. 20, 1922, that I saw him alive on Oct. 20, 1922, and that death occurred, on the date stated above, at 6:25 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Typhoid fever

(Duration) yrs. mos. 20 ds.

(Signed) John J. Krager, M. D.
Oct. 20, 1922 (Address) St. Joseph's Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Delaware

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL.

St. Stanislaus Church

DATE OF BURIAL,

Oct. 23, 1922.

20-UNDERTAKER

M. J. Sadowski

ADDRESS

405 S. Am St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 68502 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68502
113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 213 1/2 Arlington Ave. 18) Ward (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Andrew Corbin
(Residence in Baltimore: No. 213 1/2 Arlington Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE Colored	5-Single, Married, Widowed, or Divorced. (Write the word) Single
6-DATE OF BIRTH Aug 28 1922 (Month) (Day) (Year)		
7-AGE 1 mos. 20 ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE (State or Country) Baltimore		
PARENTS.	10-NAME OF FATHER Joseph Corbin	
	11-BIRTHPLACE OF FATHER (State or Country) Baltimore	
	12-MAIDEN NAME OF MOTHER Edna Louche	
	13-BIRTHPLACE OF MOTHER (State or Country) Baltimore	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Edna Corbin (Address) 213 1/2 Arlington Ave.		

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH
Oct 19 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Gastro-enteritis

CONTRIBUTORY (Secondary)
Premenstrual Strain
(Duration) yrs. mos. ds.
(Signed) J. M. D.
(Address) 700 E. Chase St.
(Coroner)
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL
Laural Cemetery
DATE OF BURIAL
Oct 21 1922

20-UNDERTAKER
Mrs Robert A. Elliott
ADDRESS 1725- Ashland St.

15- Robert P. Harrison, Jr.
Filed 27 1922 Registrar.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68503

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

217 No High St

ST.; 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Piccinini

(a) RESIDENCE, No.

(Usual place of abode)

217 No High St

ST.,

WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Infant

6 DATE OF BIRTH (month, day, and year)

Oct 20 - 22

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Cesare Piccinini

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Rosina Landi

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Cesare Piccinini 217 No High St

15

Filed

19

ROBERT F. HARRISON,

Registrar

Burial Permit Clerk:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 20

19 22

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922, to Oct 20, 19 22

that I last saw him alive on Oct 20, 19 22

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Failure to respond properly to effort of cerebral Resuscitation following Traumatic peritonitis at delivery

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Faulty resuscitation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Vahlsborn, M. D.

2/10, 19 22 (Address)

2 N. Ashby

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Church

Oct 27 19 22

20 UNDERTAKER

ADDRESS

George J. Rulth

1735

Harford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

1. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.68504 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68504

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 516 Park Ave. St. 11 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John H. Brooks

(Residence in Baltimore: No. 516 Park Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, colored 5-Single, Married, Widowed, or Divorced, (Write the words) Married

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Mrs. Rachel Brooks (Address) 516 Park Ave.

15- Robert P. Harrison, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 19, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. E. Harrison, M. D. (Coroner.) 2802 Cambridge

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS

George H. Hollins, 1031 Lombard

10.68505 HEALTH DEPARTMENT—CITY OF BALTIMORE 1068505
 100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Greenway Apts- ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Bernard Mann

(a) RESIDENCE. NO.

Greenway Apts- ST. 12 WARD. Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 80 yrs. 5 mos. 38 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Male white widower

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Annie Eader Mann

6 DATE OF BIRTH (month, day, and year) April-21-1842

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
80 5 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Patent Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

Patents

(c) Name of employer

Self

9 BIRTHPLACE (city or town) (State or country)

Zanesville Ohio

10 NAME OF FATHER

Stephen Stafford Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Providence Rhode Island

12 MAIDEN NAME OF MOTHER

Ann Hartsock

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Frederick Maryland

PARENTS

14 Informant Mr. S. B. Mann Jr. (son)

(Address) 307 Clifton Ave.

15

Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 11th 1922, to Oct 19, 1922,

that I last saw him alive on Oct 19, 1922,

and that death occurred, on the date stated above, at 6:17 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam's

(Signed) J. A. Woodcock, M. D.

, 19 (Address) 3101 Clifton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge Cemetery Oct 21 1922

20 UNDERTAKER ADDRESS

STEWART & MOWEN COMPANY 108 W. NORTH AVE.

WILLIAM F. WOODEN, (Signature)

Burial Permit Clerk.

MARGIN RESERVED FOR BINDING
 WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. See instructions on back of certificates.

D. 68506 HEALTH DEPARTMENT—CITY OF BALTIMORE *D. 68506* CERTIFICATE OF DEATH. *31*

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *514 N. Vincent.* ST.: *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lelia Tabb.

(a) RESIDENCE. No.

514 N. Vincent. ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Cauc.

5 Single, Married, Widowed, or Divorced (write the word)

*Widow.*5a If ~~married~~, widowed, or divorced HUSBAND of (or) WIFE of*Wm. Tabb.*

6 DATE OF BIRTH (month, day, and year)

Jan 11-1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*47**9**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

va

10 NAME OF FATHER

Edgar Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country)

va

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

va

14

Informant (Address)

*En Tabb
1479 Cairo St*

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 18 1922

17

I HEREBY CERTIFY, That I attended deceased from *Sept 19 1922* to *Oct 18 1922* that I last saw him alive on *Oct 18 1922*and that death occurred, on the date stated above, at *7:35 P. M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis(duration) — yrs. *3* mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

home

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Regular

(Signed)

Oct 19 1922

(Address)

1313 W. North St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Wt. Oakburn Cemetery

20 UNDERTAKER

R. L. Parham

ADDRESS

220 Hamer

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 22 1922

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 10-21-M&T-1500 Hls.

10.68507 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68507

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Mr. George F. Arnold.

(a) RESIDENCE NO.

709 W. Genny Ave., Houston, Texas

ST. 9 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

unknown yrs. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mrs. Arnold (wife)

6 DATE OF BIRTH (month, day, and year)

Aug 31, 1847

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

75

1

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(H)

(c) Name of employer

(H)

9 BIRTHPLACE (city or town) (State or country)

Rhode Island

10 NAME OF FATHER

William B. Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Millville, Mass.

12 MAIDEN NAME OF MOTHER

Matilda Darling

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Millville, Mass.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Med

Robert B. Harris Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 19, 1922, to Oct 18, 1922,
that I last saw him alive on Oct 18, 1922,

and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Shaw, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Landon Park Cemetery

DATE OF BURIAL

10/21 1922

20 UNDERTAKER

Henry W. Means & Son

ADDRESS

125 W. Calvert St.

OCT 21 1922

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

68508

HEALTH DEPARTMENT—CITY OF BALTIMORE

68508

CERTIFICATE OF DEATH

1-PLACE OF DEATH

University Hospital
Boulevard & S. E. ST.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ST. WARD)

2-FULL NAME

Robert F. Davis

(a) RESIDENCE. NO.

Ridgewood, Md ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE Years 42 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va. (State or country)

10 NAME OF FATHER R. T. Davis

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Emma V. Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Christopher J. Ester (Address) 321 E. 28th St.

15 Filed OCT 22 1922

ROBERT F. DAVIS, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21 1922

17 I HEREBY CERTIFY, That I attended deceased from 10/11 1922 to 10/21 1922.

that I last saw him alive on 10/21 1922

and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

CONTRIBUTORY (Secondary) General Antitoxin (duration) yrs. mos. 35 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of 10/19/22

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. Freedom, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Richmond Va Oct 21 1922

21 UNDERTAKER ADDRESS

Cliff Johnson 1482 N. May

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

68509 HEALTH DEPARTMENT—CITY OF BALTIMORE 68509

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.: *12* WARD)

REGISTERED NO. *968509*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Roberta J. Jurein*

(a) RESIDENCE. NO. *433 E. Lafayette St.* ST.: *12* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Matthew W. Jurein*

6 DATE OF BIRTH (month, day, and year) *Sept 30 1895*

7 AGE Years Months Days *27* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House Wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*

10 NAME OF FATHER *J. B. Barboe*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Mary E. Barboe*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Washington D. C.*

14 Informant (Address) *Matthew W. Jurein 433 E. Lafayette St.*

15 Filed *19* *ROBERT R. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 20 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 18*, 19*22*, to *Oct 20*, 19*22*, that I last saw him alive on *Oct 20*, 19*22*, and that death occurred, on the date stated above, at *8 A.* m. The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) *Ac. Pancreatitis* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Oct 19/22*

Was there an autopsy? *No*

What test confirmed diagnosis? (Signed) *S. W. Hunsley*, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Charles C. Md* DATE OF BURIAL *Oct 21*

20 UNDERTAKER *E. A. Wiedefeld* ADDRESS *501 E 12th*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 6 WARD)

2-FULL NAME Henry Petoske

(a) RESIDENCE NO. 17 N. Broadway ST., ? WARD

(Usual place of abode)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of

Sarah Petoske

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Zelick

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Kosky

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed OCT 22 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 9, 1922 to Oct 21, 1922

that I last saw him alive on Oct 21, 1922

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

Chronic Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) J. L. Houghton, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Heaven Rosedale

DATE OF BURIAL

10/22 1922

20 UNDERTAKER

Jack Lewis 1439 S. Baltimore

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *South Baltimore Hospital*
CITY OF BALTIMORE: (No. *1213 Light* ST., *15* WARD)

2-FULL NAME *Mrs. Sarah Carpmann*

(a) RESIDENCE NO. *3530 Cottage* ST.

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Abraham Carpmann*

6 DATE OF BIRTH (month, day, and year) *March 1922*

7 AGE *38* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Russia*

10 NAME OF FATHER *Morris Spector*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Russia*

12 MAIDEN NAME OF MOTHER *Elora Batrnick*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Russia*

14 Informant *Jack Lewis* (Address) *1439 E. Balt.*

15 Filed *OCT 22 1922* *ROBERT R. MAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 20 1922*

17 I HEREBY CERTIFY, That I attended deceased from *September 7, 1922*, to *October 20, 1922*, that I last saw her alive on *October 19, 1922*, and that death occurred, on the date stated above, at *10:50 a.m.* The CAUSE OF DEATH* was as follows:

Myocarditis - Endocarditis
Chronic Nephritis

CONTRIBUTORY (Secondary) *acute dilatation of heart* (duration) *unknown* yrs. mos. ds.

18 Where was disease contracted if not at place of death? *not known* Did an operation precede death? *no* Date of *Oct. 20*

Was there an autopsy? *no* What test confirmed diagnosis? *X-Ray & laboratory tests* (Signed) *M. D.*

1922 (Address) *1627 E. Balt. St.* *State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Neheer Herring Run* DATE OF BURIAL *10/22/22*

20 UNDERTAKER *Jack Lewis* ADDRESS *1439 E. Balt.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 N Carey ST., 18 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1232 W. Pratt ST.,

(Usual place of abode)
Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

OCT 22 1922

ROBERT R. MAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from
Oct 18, 1922 to Oct 20, 1922.
that I last saw him alive on Oct 20, 1922.

and that death occurred, on the date stated above, at 12 noon
The CAUSE OF DEATH* was as follows:

Malnutrition & Diarrhea

CONTRIBUTORY
(Secondary)

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

10/20, 1922

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Ruskin ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Clara Nicholson

(a) RESIDENCE

No. 2232 Ruskin ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single (Married, Widowed, or Single—use the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 25/1899

7 AGE Years 23 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

C. & P. Tel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Arthur F. Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Eva H. Heath

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14 Informant Arthur F. Nicholson (Address) 2232 Ruskin

15 Filed Oct 22 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 12, 1922, to Oct 20, 1922, that I last saw him alive on Oct 19, 1922.

and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Respiratory failure

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Pulm Th

(duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Spent Exam

(Signed) J. H. Smith, M. D.

10/24, 1922 (Address) 1302 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Wood Lawn Cemetery

DATE OF BURIAL

Oct 23 1922

20 UNDERTAKER

Wm Cook

ADDRESS

502 North

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

✓
BALTIMORE *268515*
118-002

118-002

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

H
: (NO. *Church Home & Inf.* S
Miss Louise Kramer.

338 8 Broadway

WARD

(If non-resident give city or town and State)

YES.

mos.

ds.

How long in U. S., if of foreign birth?

yze

MOS

ds

MEDICAL CERTIFICATE OF DEATH

4 COLOR OR RACE

16 DATE OF DEATH (month, day, and year) 19/10/22 1922

17

I HEREBY CERTIFY, That I attended deceased from

18/10/22, 1922, to 19/10/22, 1922.

that I last saw him alive on Wed. Oct 18th, 1922

and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Industrial Corporation International

(duration) 2 yrs. 0 mos 0 ds

CONTRIBUTORY
(Secondary)

(duration) 2 yrs. mos. da

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? Yes Date of 18/10/22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert M. Thompson as the M.D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Filed

19

— 20 —

Registrar

Revised Technical Manual

MARGIN RESERVED FOR BINDING
Every item of information should be state
PHYSICIANS should state
EXACTLY. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 14)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced. (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15

OCT 22 1922

ROBERT R. KRAUTER,
Burial Permit Registrar

WARD

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

ds. yrs. mos. ds.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18 1922

17 I HEREBY CERTIFY, That I attended deceased from
10-14 1922, to 10-18 1922.

that I last saw her alive on 10-18 1922.

and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. H. Anderson

, 19 (address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

068517 HEALTH DEPARTMENT—CITY OF BALTIMORE 068517

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View
City of BALTIMORE: (No. 15 St., 15 Ward) Registered No. C.....
2-FULL NAME Emma E. Carter
(Residence in Baltimore: No. 1109 Little Wilson St. - 30 St., yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Black 5-Single, Married, Widowed, or Divorced, Married (Write the word.)
6-DATE OF BIRTH, Unknown (Month) (Day) (Year)
7-AGE, About 35 yrs. - mos. - ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Domestic (b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Henry Yancy
11-BIRTHPLACE OF FATHER, (State or Country), Va
12-MAIDEN NAME OF MOTHER, Lillie Lewis
13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James H. Dennis
(Address) 1303 Preetman St.

15- Filed 192 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 18 (Month) (Day) (Year)
17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by Inquiry and that said deceased came to death topsy or inquiry.) on the day stated above.
The CAUSE OF DEATH was as follows: Peritonitis
(Duration) 3 days
CONTRIBUTORY Had operation performed about 1 year ago for Pott's disease (Signed) J. H. Dennis, M. D. Coroner
Oct 21 1922 (Address) Curtis Bay
*State the Disease Causing Death, or from Causes, state (1) Means of Injury; and whether Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence.
19-PLACE OF BURIAL OR REMOVAL, Date of Burial, Case Co. Joppahanock Va Oct 22, 1922
20-UNDERTAKER, ADDRESS 1303 James H. Dennis Preetman St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 E. North Ave. ST., WARD)2-FULL NAME Oliver P. Myers, Sr.(a) RESIDENCE No. 1635 E. North Ave. ST., WARDLength of residence in city or town where death occurred 87 yrs. — mos. 3 ds. How long in U. S., if of foreign birth? 87 yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of late (or) WIFE OF Eliza E. Myers6 DATE OF BIRTH (month, day, and year) Oct. 17 18357 AGE Years 87 Months — Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) MD10 NAME OF FATHER Christian H. Myers11 BIRTHPLACE OF FATHER (city or town) MD (State or country)12 MAIDEN NAME OF MOTHER Mary A. Myers13 BIRTHPLACE OF MOTHER (city or town) New Jersey (State or country)14 Informant Mr. Mrs. Myers (Address) 1635 E. North Ave.15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 20 192217 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1922, to Oct 20, 1922, that I last saw him alive on Oct 20, 1922, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
of Mitral Regurgitation of Aorta
(duration) 2 yrs. — mos. — ds.CONTRIBUTORY (Secondary) Lesson preparation
(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical Examination
(Signed) Wm. F. Taylor, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

MOYAL London Park Cemetery Oct. 23 1922

20 UNDERTAKER ADDRESS

Henry Brock Bur 1301 E. Eager St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.)

JOHNS HOPKINS HOSPITAL

ST.,

WARD)

2-FULL NAME

Mary Wilson

(a) RESIDENCE NO.

437 E. Penna. Ave.

ST.,

WARD

Towson, Md.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Albert N. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

Mary Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL.

15

Filed

OCT 22 1922

ROBERT R. KRAUTER

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 19th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 18th 1922, to Oct. 19th 1922.that I last saw him alive on Oct. 19th 1922.

and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Hypertension, myocardial infarction, chronic nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Hotel Gray.

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

Signed

Chas. W. Cunningham M. D.

19

1922

(Address)

Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Lessard Testa

20 UNDERTAKER

Samuel Hensley

ADDRESS

1922

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 N. Saratoga ST. WARD 19)2-FULL NAME Florence Hebron(a) RESIDENCE NO. 1523 N. Saratoga ST. WARD 19

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE Col.5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Hebron6 DATE OF BIRTH (month, day, and year) 1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Richmond9 BIRTHPLACE (city or town) (State or country) Richmond Va.10 NAME OF FATHER Andrew Epp.11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.12 MAIDEN NAME OF MOTHER Maria Lee13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.14 Informant (Address) John Hebron 1523 Saratoga St.15 Filed 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/19 1922

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1922 to Oct. 19, 1922.that I last saw her alive on Oct. 19, 1922.and that death occurred, on the date stated above, at 3:40 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral HemorrhageCONTRIBUTORY (Secondary) Reyes of Arteriosclerosis
(duration) yrs. mos. ds. 16
Chronic interstitial nephritis
(duration) yrs. mos. ds. 16

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) James M. Hay, M. D.1970 (Address) 1946 Penn. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

ROBERT M. KEEFER Registrar

Burial Permit Blank

TION is very important. See instructions on back of certificates.

68521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. 68521

1-PLACE OF DEATH

City of BALTIMORE: (No. 3416 Belair Rd. St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3416 Belair Rd. St.; yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-Single, Married, Widowed, or Divorced (Write the word.)

6-DATE OF BIRTH, Feb 13 1888 (Month) (Day) (Year)

7-AGE, 72 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Retired. (b) General nature of industry, business, or establishment in which employed (or employer). Grocer

9-BIRTHPLACE, (State or Country), Germany

PARENTS. 10-NAME OF FATHER, Henry Linsen 11-BIRTHPLACE OF FATHER, Germany 12-MAIDEN NAME OF MOTHER, Mary Pfundt 13-BIRTHPLACE OF MOTHER, Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anna Luerssen (Address) 3416 Belair av.

15- OCT 22 1922 ROBERT R. KRAUTER, Registrar. Filed 1922 Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 20 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry. thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy. (2nd stroke)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. S. Baker M. D. (Coroner) 6821 1922 (Address) 508 E North

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Mount Carmel Oct 23 1922

20-UNDERTAKER, ADDRESS

Louis Steeman 325 Broad way

11. 68522

HEALTH DEPARTMENT—CITY OF BALTIMORE

11. 68522

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1104 N. Canton St. 10 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1104 N. Canton St.; yrs. 57 mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married (Write the word.)

6-DATE OF BIRTH, April 2 1887 (Month) (Day) (Year)

7-AGE, 51 yrs. 6 mos. 29 ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Solemnizer (b) General nature of industry, business, or establishment in which employed (or employer), abb

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS. 10-NAME OF FATHER, John L. Lee 11-BIRTHPLACE OF FATHER, Balto Md 12-MAIDEN NAME OF MOTHER, Mary H. Kepler 13-BIRTHPLACE OF MOTHER, Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James B. Lee (Address) 1104 N. Canton

15- 221922 Robert P. HARRISON,

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 20 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage
Tuberculosis
(Duration)yrs. 5 mos.ds.

CONTRIBUTORY (Secondary) Pneumonia

(Signed) J. S. H. Taylor M. D. (Coroner.) Oct 21, 1922 (Address) 508 E. North

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death,yrs.mos.ds. In the State,yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, Oct 23rd 1922

20-UNDERTAKER, Mrs. John H. Kepler ADDRESS 508 E. North

dl. 68523 HEALTH DEPARTMENT—CITY OF BALTIMORE dl. 68523

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital* ST.: *6* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Benjamin Vickers*(a) RESIDENCE. NO. *101 N. Stuyvesant* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *51* yrs. *1* mos. *8* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Ruth Vickers*

6 DATE OF BIRTH (month, day, and year) *Sept 12 - 1871*

7 AGE Years *51* Months *1* Days *8* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Ex Police*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *Retired*9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*10 NAME OF FATHER *Jesse Vickers*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md*12 MAIDEN NAME OF MOTHER *Amanda Hughes*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md*

14 Informant *Ruth Vickers*
(Address) *101 N. Stuyvesant St*

15 Filed *Robert P. Harrison*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 20* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *Oct. 2* *1922*, to *Oct. 20* *1922*, that I last saw him alive on *Oct. 20* *1922*, and that death occurred, on the date stated above, at *11:30 a* m.

The CAUSE OF DEATH* was as follows:

*Myocardial Infarction +
chronic intestinal angina*

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *General peritonitis*(duration) yrs. mos. ds. *9*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *10/4 + 10/19*Was there an autopsy? *No*What test confirmed diagnosis? *P. S. + S.*(Signed) *Harold C. Pellety*, M. D.19 (Address) *St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Oaklawn Cemetery *Oct. 23* 19*22*

20 UNDERTAKER

ADDRESS

Mrs. Mrs. John W. Seufel & Son *801 N. Fayette*

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Strangulated Hernia

68524 HEALTH DEPARTMENT—CITY OF BALTIMORE 68524
 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1803 W Pratt St., ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Schilling

(a) RESIDENCE NO. 1803 W. Pratt St.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 1 mos.

ST. WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 20, 1877

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Ind.

10 NAME OF FATHER

Frank Schilling

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Janet Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Ind.

14

Informant (Address)

Mary Huehl 1803 W. Pratt St.

15

Filed

Revol. 19 Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 17, 1922, to Oct 20, 1922,

that I last saw him alive on Oct 20, 1922,

and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Syphilis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward H. Revell, M. D.

10/22/22 (Address) 24 W. Fullam St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral

Oct 23 1922

20 UNDERTAKER

ADDRESS

Harry H. Witzke

531 W. Lombard St.

21922

Burial Permit Clerk:

D. 68525 HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 68525

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 218 N. Arlington Ave. ST. 18 WARD)

2-FULL NAME

Alice Victoria Price

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

218 N. Arlington Ave

WARD

Length of residence in city or town where death occurred

Life

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX

Female

COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 23/1901

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

21

7

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Robert Price

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mamie Dargatzis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Robert Price 218 N. Arlington Ave

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

October 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 3, 1921 to Oct 19, 1922

that I last saw her alive on Oct 18, 1922

and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Pulmonary

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. J. Howell M. D. 119 N. Carrollton Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Laural Cemetery

Oct 22, 1922

20 UNDERTAKER

ADDRESS

John H. Tardwin

142 N. Hill

TION is very important. See instructions on back of certificate.

DL. 68526 HEALTH DEPARTMENT—CITY OF BALTIMORE *DL. 68526* CERTIFICATE OF DEATH. *74-001*

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *815 Edmondson* ST., *18* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Michael S. Brooks

(a) RESIDENCE NO.

815 Edmondson

ST.,

WARD

(Usual place of abode)

about 65 yrs.

mos.

ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? *65* yrs.

mos.

ds.

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Catherine A. Butler

6 DATE OF BIRTH (month, day, and year)

Aug 23/47

7 AGE

75

Years

Months

Days

*1**27*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Proprietor Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

Wagon Truck Building

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Edwin M. Brooks 815 Edmondson St.

15

Robert F. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 20 1922

17

I HEREBY CERTIFY, That I attended deceased from *Jan 22*, 19*14*, to *Oct 20*, 19*22*, that I last saw him alive on *Oct 20*, 19*22*, and that death occurred, on the date stated above, at *11 9* a. m.

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage followed by degeneration*CONTRIBUTORY (Secondary) *Coma* (duration) *8* yrs. *9* mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *none*(Signed) *H. E. Knapp*, M. D. *1922* (Address) *1002 W. Zauvale*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Funeral Home

DATE OF BURIAL

Oct 23 1922

20 UNDERTAKER

John J. Brown

ADDRESS

31 Holbrook St.

TION is very important. See instructions on back of certificates.

221922

Burial Permit Clerk.

68527 HEALTH DEPARTMENT—CITY OF BALTIMORE 68527

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 S. Stricker St. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

John Robert Nicholson

(a) RESIDENCE NO. 221 S. Stricker St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor Nicholson

6 DATE OF BIRTH (month, day, and year) Aug. 23rd 1849

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 73 1 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Powhattan (State or country) Md.

10 NAME OF FATHER Richard Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Torney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Eleanor Nicholson (Address) 221 S. Stricker St.

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19th 1922

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19th 1922 to Oct. 18th 1922, that I last saw him alive on Oct. 18th 1922 and that death occurred, on the date stated above, at 8.15 P. m. The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(duration) 4 yrs. 0 mos. 0 ds. CONTRIBUTORY (Secondary) Asthenia & Pnc. long. (duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Don't know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. G. Warner, M. D.

10/20/22 Address) 119 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Mt. Olivet Cem. Oct. 22nd 1922

20 UNDERTAKER ADDRESS

Joseph B. Cook 1003 N. Baltimore St.

UTION is very important. See instructions on back of certificates.

221922

Margaret W. Ayda
 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1935 E. Wommumet St.

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Margaret W. Ayda

(Residence in Baltimore: No.

1935 E Wommumet

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,

Married
 MARRIED,
 WIDOWED,
 OR DIVORCED,
 (Write the word.)

6-DATE OF BIRTH,

12

(Month)

25

(Day)

1922

(Year)

7-AGE,

9 yrs. 9 mos. 21 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),*City*

10-NAME OF FATHER,

*Charles Ayda*11-BIRTHPLACE OF FATHER
(State or Country),*City*

12-MAIDEN NAME OF MOTHER

*Margaret Thorne*13-BIRTHPLACE OF MOTHER
(State or Country),*City*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Charles Ayda*(Address) *1935 E Wommumet St.*

15-

Filed

OCT 23 1922

191

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

10

(Month)

21

(Day)

1922

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Oct. 15 1922, to Oct 21 1922*that I saw her alive on *Oct 20 1922*,and that death occurred, on the date stated above, at *5:30* m.

The CAUSE OF DEATH* was as follows:

Compensated Valvular Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY *Acute Bronchitis*

(Secondary)

(Duration) yrs. mos. ds.

(Signed) *John Ayda* M. D.*Oct. 21, 1922* (Address) *1935 E Wommumet St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Redeemer

DATE OF BURIAL,

Oct. 23, 1922

20-UNDERTAKER

William Schaeffer

ADDRESS

1935 E Wommumet St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

68529

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 68529

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE; (No. 531 Washington Blvd ST. 22 WARD)

2. FULL NAME

Edward John Bowman

(a) RESIDENCE NO.

531 Washington Blvd ST. 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Lifetime mos. 0 yrs. 0 ds.

How long in U. S. If of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Ray Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Shart

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

North Carolina

14

Informant (Address)

Ray Bowman
531 Washington Blvd

15

OCT 23 1922

ROBERT R. MAUTER,

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 22, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1922 to Oct 22, 1922

that I last saw him alive on Oct 22, 1922

and that death occurred, on the date stated above, at 2:50 A. m.

The CAUSE OF DEATH* was as follows:

Breech presentation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

10 1/2 lbs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. B. Greener, M. D.

1022 1922 Address 22 Columbia St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cem

Oct 23 1922

20 UNDERTAKER

ADDRESS

for founders Son

217 S. Pen

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68530 HEALTH DEPARTMENT—CITY OF BALTIMORE 68530
CERTIFICATE OF DEATH.
1-PLACE OF DEATH
City of BALTIMORE: (No. 1014 Madison Avenue St. 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME Louisiana Perkinson
(Residence in Baltimore: No. 1014 Madison Avenue St. 11 yrs. 11 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, Widowed (Write the word.)
6-DATE OF BIRTH, November 26, 1840 (Month) (Day) (Year)
7-AGE, 81 yrs. 11 mos. 24 ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work, None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore, Maryland

PARENTS.
10-NAME OF FATHER, William Bennett
11-BIRTHPLACE OF FATHER, (State or Country), Virginia
12-MAIDEN NAME OF MOTHER, Ann Atkinson
13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Kate McCarthy
(Address) 1014 Madison Avenue

15- OCT 23 1922 ROBERT R. MAUTER, Registrar.
Filed. 10: Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 20, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and, from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Myocardial disease
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) ~~Heart~~ Branches, pneumonia
(Duration) yrs. mos. ds.
(Signed) J. L. H. H. M. D. (Coroner)
Oct. 22, 1922 (Address) 2802 E. ...

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence.
19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Loudon Park Cemetery 10/23, 1922
20-UNDERTAKER, ADDRESS, Henry W. Years & Son 805 N. Calvert St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Mc Elderry ST.;

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1512 Mc Elderry Balto Md. St.; 25 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) widowed

6-DATE OF BIRTH,

 , 1865
(Month) (Day) (Year)

7-AGE,

57 yrs., mos., ds.If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cubover
Stevados9-BIRTHPLACE,
(State or Country),Md.

10-NAME OF FATHER,

John Maddox11-BIRTHPLACE OF FATHER
(State or Country),Md.

12-MAIDEN NAME OF MOTHER

unknown13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Gross(Address) 1405 Mc Elderry St

Filed

191

ROBERT R. WARDEN
Bureau of Health
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

10 22, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1922, to Oct. 22 1922,that I saw him alive on Oct 20 1922,and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Amnesia of Sortu(Duration) in certain yrs., mos., ds.CONTRIBUTORY
(Secondary)(Duration) yrs., mos., ds.(Signed) R. J. Gross M. D.10/20, 1922 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

LaurelOct. 26, 1922

20-UNDERTAKER

ADDRESS

R. J. Gross 1405 Mc Elderry St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

068532

HEALTH DEPARTMENT—CITY OF BALTIMORE

068532

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. *Provident Hospital* ST., *11* WARD)
2-FULL NAME *Nancy Richardson*
(a) RESIDENCE NO. *Anne Arnold Co., Md.* ST., _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. *123* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Caucasian* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *J. W. Richardson*

6 DATE OF BIRTH (month, day, and year) *Aug. 12-1870*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *52*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Domestic*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Anne Arnold Co., Md.* (State or country)

10 NAME OF FATHER *Isaac Brown*

11 BIRTHPLACE OF FATHER (city or town) *Prince Geo. Co., Md.* (State or country)

12 MAIDEN NAME OF MOTHER *Queen*

13 BIRTHPLACE OF MOTHER (city or town) *Prince George Co., Md.* (State or country)

14 Informant *J. W. Richardson* (Address) *Edwardsville, Northumberland Co., Pa.*

15 Filed *19* *ROBERT R. KRAUTER* Registrar

OCT 23 1922

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10-20-* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from *4-29-22*, 19 *22*, to *10-20-* 19 *22*, that I last saw him alive on *10-20*, 19 *22*, and that death occurred, on the date stated above, at *6:50 p. m.* The CAUSE OF DEATH* was as follows:

Tuberculosis (Lung)

(duration) yrs. *8* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Unknown*

Did an operation precede death? *No* Date of _____

Was there an autopsy? *No*

What test confirmed diagnosis? *None*

(Signed) *George C. Payne*, M. D.

, 19 (Address) *1720 N. Mount St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Greenwood Co. to Ind. Co.

20 UNDERTAKER *Mrs. Robert A. Elliott* ADDRESS *1725*

Oakland

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *833 Rutland* ST. *16* WARD)2-FULL NAME *Jeremiah Griffin*(Residence in Baltimore: No. *833 Rutland* St.; *35* yrs., *—* mos., *—* ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *W.C.*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Feb 20 1892*

(Month)

(Day)

(Year)

7-AGE, *30 yrs. 8 mos. 1 ds.*

If LESS than 1 day,hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *Butler (Private home)*(b) General nature of industry, business, or establishment in which employed (or employer) *70*9-BIRTHPLACE, (State or Country), *md.*10-NAME OF FATHER, *Jeremiah Griffin*11-BIRTHPLACE OF FATHER (State or Country), *md.*12-MAIDEN NAME OF MOTHER *Rebecca Smith*13-BIRTHPLACE OF MOTHER (State or Country), *md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Emma Griffin*(Address) *833 Rutland*

16-

Filed *OCT 23 1922*

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 20 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 6 1922* to *Oct 20 1922*that I saw him alive on *Oct 20 1922*and that death occurred, on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) *14* yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary)

(Duration) *10* yrs. *—* mos. *—* ds.(Signed) *J. B. Lusk**Oct 22 1922* (Address) *1313 W. Mt. Vernon*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *—* yrs. *—* mos. *—* ds. In the State *—* yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Mt-Aurthur Cem*DATE OF BURIAL, *Oct-23 1922*20-UNDERTAKER, *Mrs Robert A Elliott*ADDRESS *1725 Ashland St*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1990 Bks.

George F Behn
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Maryland General Hospital* REGISTERED NO. *68534*
CITY OF BALTIMORE: No. *129* ST. *9* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)
2-FULL NAME *George F. Behn*
(a) RESIDENCE. No. *504 Somerset Ave* ST. *9* WARD. *9*
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. *1* ds. *1* How long in U. S., if of foreign birth? yrs. *1* mos. *1* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of *Anna Behn* (or) WIFE of *June 24 1881*

6 DATE OF BIRTH (month, day, and year)

7 AGE Years *41* Months *3* Days *24* If LESS than 1 day, hrs. *0* or min. *0*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *clock*
(b) General nature of industry, business, or establishment, in which employed (or employer) *Ind. Mutu Works*
(c) Name of employer

9 BIRTHPLACE (city or town) *Maryland* (State or country)

10 NAME OF FATHER *Geo F Behn*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *Anna Rohl*

13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14 Informant (Address) *Anna Behn 504 Somerset Ave*

15 Filed *OCT 23 1922* ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 20 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 5*, 19*22*, to *Oct 20*, 19*22*, that I last saw h. *alive* on *Oct 20*, 19*22*, and that death occurred, on the date stated above, at *5:15-4* m. The CAUSE OF DEATH* was as follows:

1. *Raynaud's Disease*
2. *Chronic Nephritis*

(duration) yrs. *3* mos. *4* ds.

CONTRIBUTORY (Secondary) *Acute Chlorosis*

(duration) yrs. *4* mos. *4* ds.

18 Where was disease contracted if not at place of death? *at home*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical*

(Signed) *James Hubert Williams* M. D.

19 (Address) *Md. Gen. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL *St. Agnes* DATE OF BURIAL *Oct 24 1922*

21 UNDERTAKER *Joseph Sefer* ADDRESS *1600 W. North Ave*

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Bka.

268535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 268535

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Saul

(a) RESIDENCE NO. Unknown ST. _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1862
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
60 -- --

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 OCT 23 1922 ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 19 19 22
17

I HEREBY CERTIFY, That I attended deceased from December 2 19 22 to October 19 19 22, that I last saw him alive on October 18 19 22, and that death occurred, on the date stated above, at 8:15 A.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 7 yrs. mos. ds.
CONTRIBUTORY (Secondary) Hypertension
(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Cl. B.P.
(Signed) Chas. M. M. M. M. D.

9/19/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL Oct 21 19 22
ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hosp.
CITY OF BALTIMORE: (No. Eastern Ave. 76 ST., 10 WARD)
2-FULL NAME Charles Repley
(a) RESIDENCE No. Bay View Apt. 10 ST., 10 WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) 1850
7 AGE Years 72 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Sto
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country)

14 Informant Hospital Records (Address)

15 0012319222 ROBERT R. MAUTER
Burial Permit 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-18 1922

17 I HEREBY CERTIFY, That I attended deceased from 3-16 1922, to 10-18 1922, that I last saw him alive on 10-18 1922, and that death occurred, on the date stated above, at 3. a. m.
The CAUSE OF DEATH* was as follows:

Senility.

(duration) yrs. mos. ds.
CONTRIBUTORY Broncho-pneumonia (Secondary)
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. Richardson Snyder M. D.

13-13 1922 - (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Oct 21 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Rufus McNeil
HEALTH DEPARTMENT—CITY OF BALTIMORE

68537

CERTIFICATE OF DEATH

1-PLACE OF DEATH
City of BALTIMORE: (No. Union Station St. 11 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rufus McNeil
(Residence in Baltimore: No. Richmond Ave. St.; yrs., mos. ds.)

3-SEX Male 4-COLOR OR RACE White 5-Single, Married, Widowed, or Divorced. Married
(Write the word.)

6-DATE OF BIRTH. (Month) (Day) (Year)

7-AGE 45 If LESS than 1 day, yrs. mos. ds. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Manager
(b) General nature of industry, business, or establishment in which employed (or employer). 886

9-BIRTHPLACE (State or Country). Pa.

PARENTS

10-NAME OF FATHER. —

11-BIRTHPLACE OF FATHER (State or Country). —

12-M maiden NAME OF MOTHER. —

13-BIRTHPLACE OF MOTHER (State or Country). —

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert R. Krauter
(Address) Baltimore, Md.

15- OCT 23 1922 1922 ROBERT R. KRAUTER
Burial Permit Register

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH. Oct. 21 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest and that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.
The CAUSE OF DEATH* was as follows:
Valvular Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Robert R. Krauter M. D.
(Coroner) Robert R. Krauter
1922 (Address) Baltimore

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. ROANOKE VA DATE OF BURIAL. Oct 25 1922

20-UNDERTAKER. ROBERT BROOKS & SON ADDRESS CoR CALHOUN HOLLINS ST S

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1920 Bks.
Inf of Jno + Anne Myers
HEALTH DEPARTMENT—CITY OF BALTIMORE
D68538 100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: No. *2124 Hunt* ST. *14* WARD *14*
2-FULL NAME *Baby Jno Ann (not named)*
(a) RESIDENCE. No. *2124 Hunt* ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS
3 SEX *Male* 4 COLOR OR RACE *Caucasian* 5 Single, Married, Widowed, or Divorced (write the word) *Single*
5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) *Oct. 16, 1922*
7 AGE Years Months Days If LESS than 1 day, hrs. or min. *6*
8 OCCUPATION OF DECEASED *None*
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country) *Baltimore, Maryland*
10 NAME OF FATHER *John Myers*
11 BIRTHPLACE OF FATHER (city or town) (State or country) *USA*
12 MAIDEN NAME OF MOTHER *Anne Herman*
13 BIRTHPLACE OF MOTHER (city or town) (State or country) *USA*

14 Informant (Address) *John Myers 2124 Hunt St.*
15 Filed *OCT 23 1922* *ROBERT R. KRAUTER* Registrar
Bridal Permit Blank

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) *10/22* 19*22*
17 I HEREBY CERTIFY, That I attended deceased from *10/22*, 19*22*, to *10/22*, 19*22*, that I last saw him alive on *10/22*, 19*22*, and that death occurred, on the date stated above, at *9:40* a.m.
The CAUSE OF DEATH* was as follows:
Pneumonia
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *Pneumonia* (duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? *no* Date of
Was there an autopsy? *no*
What test confirmed diagnosis?
(Signed) *Arthur H. H. H.* M. D.
19 19*22* (Address) *2124 Hunt St.*
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Mt. Auburn* DATE OF BURIAL *Oct. 23 1922*
20 UNDERTAKER *James W. Dumb* ADDRESS *1313*

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks. **D 68539**
159108 HEALTH DEPARTMENT—CITY OF BALTIMORE **D 68639**
31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. **JOHNS HOPKINS HOSPITAL**, ST., **6** WARD)

2-FULL NAME **Ruth Zahner.**
(a) RESIDENCE NO. **28 N. Maclaria St. City** WARD _____
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred **Unknown** yrs. ds. How long in U. S., if of foreign birth? _____ yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **Female** 4 COLOR OR RACE **White** 5 Single, Married, Widowed, or Divorced, (write the word) **Married.**
5a If married, widowed, or divorced **husband of** **John Zahner (husband)** or) WIFE of
6 DATE OF BIRTH (month, day, and year) **Sept 5th - ?**
7 AGE Years **23** Months **?** Days **?** If LESS than t day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work **H. W.**
(b) General nature of industry, business, or establishment in which employed (or employer) **U. H.**
(c) Name of employer **U. H.**
9 BIRTHPLACE (city or town) (State or country) **U. H.**
PARENTS
10 NAME OF FATHER **Mike Gott.**
11 BIRTHPLACE OF FATHER (city or town) (State or country) **U. H.**
12 MAIDEN NAME OF MOTHER **Mary McIlwaine**
13 BIRTHPLACE OF MOTHER (city or town) (State or country) **U. H.**
14 Informant **JOHNS HOPKINS HOSPITAL.**
(Address) **1900 Robert R. Krauter,**
OCT 23 1922 Filed **19** Registrar **Burial Permit Clerk**

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) **Oct 19 1922**
17 I HEREBY CERTIFY, That I attended deceased from **Oct 16 1922** to **Oct 19 1922**, that I last saw her alive on **Oct 19 1922**, and that death occurred, on the date stated above, at **140 A. M.**
The CAUSE OF DEATH* was as follows:
Post. oper. bronch. pneumonia
tubercles in liver, spleen & lung.
(duration) _____ yrs. mos. ds.
CONTRIBUTORY **operation for heart**
(Secondary) **appendicitis** (duration) _____ yrs. mos. ds.
18 Where was disease contracted _____ if not at place of death?
Did an operation precede death? **yes** Date of **Oct. 16-22**
Was there an autopsy? **yes**
What test confirmed diagnosis? **autopsy**
(Signed) **R. H. M. D.**
(Address) **John Hopkin Hospital**
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)
19 PLACE OF BURIAL, CREMATION OR RE-MOVAL **Baltimore Cemetery** DATE OF BURIAL **Oct 23 1922**
20 UNDERTAKER **H. Vander & Sons** ADDRESS **710 Fleet St.**

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2304 E. Madison ST.)

WARD)

2-FULL NAME

Minnie G. Hoffman

(a) RESIDENCE

No. 2304 E. Madison ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year)

August 25-1875

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

47

1

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Seamstress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hanover Pa

10 NAME OF FATHER

Charles L. Hoffman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Mary C. Stahl

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Hanover Pa.

14

Informant (Address)

Mrs. Mary C. Hoffman 2304 E. Madison St.

15

Filed

OCT 23 1922

ROBERT R. KRALTER,

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1 1922 to Oct 21 1922

that I last saw him alive on Oct 21 1922

and that death occurred, on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes — Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed)

19 (Address) 500 N. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hanover Pa

Oct 24 1922

20 UNDERTAKER

ADDRESS

H. J. Anderson & Sons 1710 E. Paul St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D-68541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-68541

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712, Riggs Ave ST. 16 WARD)

2-FULL NAME

Rachael Lake

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1712 Riggs Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas H Lake

6 DATE OF BIRTH (month, day, and year) Oct 9-1871

7 AGE 51 Years Months Days 05 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Landscaper

(b) General nature of industry, business, or establishment in which employed (or employer) Landscaping

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. Ind. (State or country)

10 NAME OF FATHER Ben Jayson

11 BIRTHPLACE OF FATHER (city or town) Howard Co. Ind. (State or country)

12 MAIDEN NAME OF MOTHER Rachael Lake

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country)

14 Informant Griffith Lee (Address) 1712 Riggs Ave

15 OCT 23 1922 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 20 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 1922, to Oct 20, 1922, that I last saw him alive on Oct 19, 1922, and that death occurred, on the date stated above, at 5:30 P. m. The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Thomas Nelson, M. D.

, 19 (Address) 1021 N. Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Auburn Cem

Oct-23, 1922

20 UNDERTAKER

Mrs Robert A. Ellison Ashland

ADDRESS 1725

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hospital* ST., *5* WARD)

2-FULL NAME *William Mc Kay Smith*

(a) RESIDENCE NO. *2647 Colvin St.* ST., *5* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *24* yrs. *5* mos. *5* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. *68542*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unk*

7 AGE Years *19* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Philadelphia* (State or country) *Pennsylvania*

10 NAME OF FATHER *Henry Smith*

11 BIRTHPLACE OF FATHER (city or town) *Va.* (State or country)

12 MAIDEN NAME OF MOTHER *Ella Wood*

13 BIRTHPLACE OF MOTHER (city or town) *Va.* (State or country)

14 Informant *Bay View Record* (Address)

15 Filed *OCT 23 1922* *ROBERT R. KRAUTER,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 20* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 19*, 19 *22*, to *Oct 20*, 19 *22*, that I last saw him alive on *Oct 20*, 19 *22*, and that death occurred, on the date stated above, at *2* P.m.

The CAUSE OF DEATH* was as follows: *Pulmonary tuberculosis*

(duration) *1* yrs. *2* mos. *2* ds.

CONTRIBUTORY *J. B. Langgitz* (Secondary)

(duration) *1* yrs. *1* mos. *2* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? *X-Ray*
(Signed) *Francis J. Indagliocco*, M. D.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Laural Cemetery*

DATE OF BURIAL

20 UNDERTAKER *Mrs Robert A Elliott* ADDRESS *1725 - Ashland St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

68543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68543

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 V. Gilmore ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Edith B. Ford

(a) RESIDENCE NO. 1536 V. Gilmore ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

6 DATE OF BIRTH (month, day, and year) Aug 10 1891
7 AGE Years Months Days If LESS than 1 day, hrs. or min. 91

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Va.

10 NAME OF FATHER James Andrew

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Lucy J Adams

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant John J Ford (Address) 1536 V. Gilmore

15 061231922 ROBERT R. KRAUTER, Registrar

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 19 22, to Oct 22, 19 22, that I last saw her alive on Oct 21, 19 22, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Regurgitation

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary)

Senile Degeneracy

(duration) Some yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) G. Lettice Ewell, M. D.

1922 (Address) 905 V. Gilmore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Mary's Cemetery DATE OF BURIAL Oct 24 19 22

20 UNDERTAKER Clark

ADDRESS 1536 V. Gilmore

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lks.

68544

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001
68544

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,
CITY OF BALTIMORE: (No. FORT MCHENRY, MD. ST. 11 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Carroll Handy

(a) RESIDENCE No. 1328 McCullough
(Usual place of abode) Baltimore, Md.

ST. _____ WARD _____
(If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) --

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
26 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) Maryland
(State or country) --

10 NAME OF FATHER --

11 BIRTHPLACE OF FATHER (city or town) --
(State or country) --

12 MAIDEN NAME OF MOTHER --

13 BIRTHPLACE OF MOTHER (city or town) --
(State or country) --

14 Informant Hospital Records
(Address) Fort McHenry, Md.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 21 1922.

17 I HEREBY CERTIFY, That I attended deceased from October 15, 1922, to October 21, 1922.

That I last saw him alive on October 21, 1922.

and that death occurred, on the date stated above, at 2:35 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) --

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? --

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? --

(Signed) [Signature] M. D.
12/21/22 Surgeon (R)
(Address) Fort McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

National Cemetery

10/23. 22

20 UNDERTAKER

ADDRESS 1117

S. Linscott & Co.

E. Balt.

OCT 23 1922

Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hopkins Apt*
CITY OF BALTIMORE: No. *St Paul 831st St* ST. *12* WARD)
2-FULL NAME *Alice Louise Thompson*
(a) RESIDENCE. No. *St Paul 831st St* ST. WARD.
(Usual place of abode)
Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*
5a If married, widowed, or divorced—
HUSBAND of (or) WIFE of *Single*
6 DATE OF BIRTH (month, day, and year) *Unknown*
7 AGE Years Months Days If LESS than 1 day, hrs. or min.
about 84

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at Home*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER *Judge P. Thompson*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va*

12 MAIDEN NAME OF MOTHER *Susan B. Tapscott*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va*

14 Informant *Wm E E Hull*
(Address) *Hopkins Apt*

15 Filed *19* *Robert F. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 22 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct. 19*, 19*22*, to *Oct. 22*, 19*22*, that I last saw *her* alive on *Oct. 22*, 19*22*, and that death occurred, on the date stated above, at *4:30 P. M.*
The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds. *3*
CONTRIBUTORY *Edema of the lungs*
(Secondary) (duration) yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death? *No*

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *No*

What test confirmed diagnosis? *Physical symptoms*
(Signed) *A. F. Robinson* M. D.
, 19 (Address) *1307 N. Charles St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Stanton* DATE OF BURIAL *Oct 24 1922*

20 UNDERTAKER *Mary Jenkins* ADDRESS *Orchard*

Spec. 1-10-21 M&T 1500 Bka.
20.68546 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68546
74-001
1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 407 W 26 ST. 12 WARD)
2-FULL NAME William A Knight
(a) RESIDENCE NO. 407 W 26 ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
PERSONAL AND STATISTICAL PARTICULARS
3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of
6 DATE OF BIRTH (month, day, and year) Aug 10 1877
7 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town) (State or country) And
10 NAME OF FATHER Elmer Knight
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Mary A Carroll
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md
14 Informant Mary A Knight
(Address) 407 W 26 St
15 Filed 23 1922 Registrar
16 DATE OF DEATH (month, day, and year) Oct 23 1922
17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1922, to Oct 23, 1922, that I last saw him alive on Oct 23, 1922, and that death occurred, on the date stated above, at 1239 A.M.
The CAUSE OF DEATH* was as follows:
Paralysis
(duration) 2 yrs. 2 mos. 13 ds.
CONTRIBUTORY (Secondary) (duration) 12 yrs. 11 mos. 25 ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signature) R. A. [illegible] M. D.
(Address) 112 W 25th St
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)
19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL
20 UNDERTAKER Address
Chenoweth Son Chestnut

Spec. 1-10-21 M&T 1500 Bka.

20.68546 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68546
74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 W 26 ST. 12 WARD)

2-FULL NAME William A Knight

(a) RESIDENCE NO. 407 W 26 ST. WARD

(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 10 1877

7 AGE 45 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) And

10 NAME OF FATHER Elmer Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary A Knight
(Address) 407 W 26 St

15 Filed 23 1922 Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1922

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1922, to Oct 23, 1922, that I last saw him alive on Oct 23, 1922, and that death occurred, on the date stated above, at 1239 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis
(duration) 2 yrs. 2 mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) 12 yrs. 11 mos. 25 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signature) R. A. [illegible] M. D.

(Address) 112 W 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

St Marys Hampden Oct 25 1922

20 UNDERTAKER ADDRESS

Chenoweth Son Chestnut

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Rks.

20.68547 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68547
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD) 4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Depkin

(a) RESIDENCE No. 222 Wolfe St.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

--

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8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Maryland

10 NAME OF FATHER

Henry Depkin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Cathryn Thurny

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant:

Hospital Records,

(Address)

Municipal Hospital.

15

Filed

Robert P. Harrison,

19

Registrar

Burial Permit City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 21 1922

17

I HEREBY CERTIFY, That I attended deceased from January 17, 1922, to October 21, 1922,

that I last saw him alive on October 20, 1922,

and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Aut. Neph. Sect. Bal.

(Signed) Clyde A. Neill M. D.

10/31/22 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart. Am.

DATE OF BURIAL

Oct. 24 1922

20 UNDERTAKER

Lilly & Zuber

ADDRESS

203 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Ills.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: NO.

JOHNS HOPKINS HOSPITAL

ST., 7

WARD)

2. FULL NAME

Joseph Richmeir

(a) RESIDENCE NO.

Hallers Point, Md.

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

unknown

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

unknown

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mrs. Emma Schultz (friend)

6 DATE OF BIRTH (month, day, and year)

Feb. 24, 1862

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

7

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town)

(State or country)

Germany

10 NAME OF FATHER

Isadore Richmeir

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Effie Kreffler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

, 19

Barial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 29, 1922, to Oct 18, 1922,

that I last saw him alive on Oct 18, 1922,

and that death occurred, on the date stated above, at 240 P. M.

The CAUSE OF DEATH* was as follows:

Brinko-pneumonia,
post-operative

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Pulmonary occlusion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Johns Hopkins Hospital

Did an operation precede death?

yes

Date of Oct. 2, 1922

Was there an autopsy?

yes

What test confirmed diagnosis?

Phys. Ex. & Autopsy

(Signed)

Guydo Feabutte, M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

2261 2 120

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Tubercular Bursitis of
Left Hip*

HEALTH DEPARTMENT—CITY OF BALTIMORE *10.68549*

91-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1918 E 12th ST. 12 WARD

(Usual place of abode)				(If non-resident give city or town and State)			
Length of residence in city or town where death occurred	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.
10	0	0	0	10	0	0	0

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 02/22/22

17
I HEREBY CERTIFY, That I attended deceased from
Sept 1, 19*22*, to *Oct 22*, 19*22*.
that I last saw him alive on *Oct. 14*, 19*22*.

and that death occurred, on the date stated above, at 739

The CAUSE OF DEATH* was, as follows:

Demility.
Arterio Sclerosis

(duration) yrs. mos. ds

CONTRIBUTOR (Secondary) *John T. Brown*

(duration) yrs. mos. ds

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? Typical Exam

(Signed) Robert B. Leides M. D.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL

Howe Redemer Oct 22, 99

20 UNDERTAKER	ADDRESS
---------------	---------

Washed by April 8th 378 no

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Hemorrhage

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

DL. 68550 HEALTH DEPARTMENT—CITY OF BALTIMORE DL. 68550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2133 Remond Ave St. 70 Ward)

Registered No. C.....

2-FULL NAME Charles E. Mantler

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2133 Remond Ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, Married

6-DATE OF BIRTH, Oct 11 1892 (Month) (Day) (Year)

7-AGE, 40 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Pipe Fitter (b) General nature of industry, business, or establishment in which employed (or employer), Dry Goods

9-BIRTHPLACE, (State or Country), Balt. City

10-NAME OF FATHER, John S. Mantler

11-BIRTHPLACE OF FATHER, (State or Country), Balt. City

12-MAIDEN NAME OF MOTHER, Rebecca Sammons

13-BIRTHPLACE OF MOTHER, (State or Country), Balt. City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Elmer W. Mantler

(Address), 2133 Remond Ave

15- Robert K. Harrison, Registrar.

Filed 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 22 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). (Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. 6 mos. ds.

(Signed) James M. McEnton M. D. (Coroner.)

Oct 22 1922 (Address) 700 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cathedral, Oct 25 1922

20-UNDERTAKER, ADDRESS

Elmer W. Conklin 324 E. Eager St.

N. B. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

00.68551 HEALTH DEPARTMENT—CITY OF BALTIMORE 00.68551

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secour Hospital ST. 16 WARD)

2-FULL NAME Miss Georgiana Carter

(a) RESIDENCE NO. 1625 Harlem Ave. ST. 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Unknown 1865

7 AGE Years 57 Months Unknown Days Unknown If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework Self

(h) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard County (State or country) Md.

10 NAME OF FATHER George Carter

11 BIRTHPLACE OF FATHER (city or town) N. J. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Samuel A. Carter (Address) 1625 Harlem Ave.

15 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 22, 19 22, to Oct 22, 19 22.

that I last saw her alive on Oct 22, 19 22.

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted not known if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Chas. H. Lacey M. D.

Oct 23, 19 22 (Address) Bon Secours Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Rosedown Park Cem.

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 1/2 Baltimore

Burial Permit

D.68552

HEALTH DEPARTMENT—CITY OF BALTIMORE

D.68552

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

1807 Madison Ave. St.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Julius Lindeman

(a) RESIDENCE. NO.

1807 Madison Ave. St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 20 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Minnie L. Lindeman

6 DATE OF BIRTH (month, day, year)

October 1858

7 AGE

64

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Real Estate Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

1

9

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Moses Lindeman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don & Knorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

Mrs. Sanders L. Schaeffer

(Address)

2414 Eastern Place

15

Filed

Robert P. Harrison

Registrar

Burial Permit 6122.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 22 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1922, to October 1922

that I last saw him alive on Oct 20, 1922

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Atherosclerosis - angina pectoris

(duration) 6 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Edema of lungs

(duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

✓

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed) J. Frederick Lutz, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Hebrew Friendship Co.

DATE OF BURIAL

10/24 1922

20 UNDERTAKER

J. Ahrens Co 1611 Kenton

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bk.

DL 68553

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL 68553

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 S. Eden ST., 3 WARD)

2-FULL NAME

Andrew J. Burns.

(a) RESIDENCE NO.

707 S. Eden

ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. _____

How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Ida Burns.

6 DATE OF BIRTH (month, day, and year) Apr. 5 1886

7 AGE Years 61 Months 6 Days 17 If LESS than 1 day, _____ hrs. _____ or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fertilizer mfg.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

Ind.

10 NAME OF FATHER

Andrew J. Burns.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Bridget Beatty

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland.

14

Informant (Address)

Andrew J. Burns.
707 S. Eden St

15

Filed

Robert E. HARTMAN.

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 10, 1922, to Oct 22, 1922, that I last saw him alive on Oct 22, 1922, and that death occurred, on the date stated above, at 7 m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(over)
(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) J. H. Hartman, M. D.

19 (Address) 141 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral

DATE OF BURIAL

Oct 25 1922

20 UNDERTAKER

John A. Moran 3000 E Balto St

ADDRESS

10. 68554

HEALTH DEPARTMENT—CITY OF BALTIMORE

10. 68554

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3405 Greenmount ST.; 9

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Patrick J. Healy

(Residence in Baltimore: No. 3405 Greenmount

St.; 60 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

Jan 6, 1854
(Month) (Day) (Year)

7-AGE,

68 yrs., 9 mos., 15 ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Retired
Summit Bldg. Co.
B.O. R.R.9-BIRTHPLACE,
(State or Country).

Ireland.

PARENTS.

10-NAME OF FATHER,

J. Healy.

11-BIRTHPLACE OF FATHER
(State or Country).

Ireland

12-MAIDEN NAME OF MOTHER

Mary Burchel

13-BIRTHPLACE OF MOTHER
(State or Country).

Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

W. Healy

(Address)

3405 Greenmount Ave.

15-

Robert F. Harrison,

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 21, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Aug 10, 1922, to Oct 21, 1922, that I saw him alive on Oct 21, 1922, and that death occurred, on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lung
(Duration) 2 yrs., mos., ds.
CONTRIBUTORY
(Secondary)
(Duration) yrs., mos., ds.
(Signed) J. P. Fussellburgh M. D.
Oct 22, 1922 (Address) 632 Gasconade

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St Mary's Burial

DATE OF BURIAL,

Oct. 24, 1922

20-UNDERTAKER

J. P. Fussellburgh

ADDRESS

2620 St Paul

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 23 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 68555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 D 68555

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5240 Main St

ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Benjamin F. Grover

(a) RESIDENCE. NO. 5240 Main

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Alvinda Grover

6 DATE OF BIRTH (month, day, and year)

Sept 12-1859

7 AGE

63

Years

1

Months

12

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto City

10 NAME OF FATHER

Louis Grover

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa

12 MAIDEN NAME OF MOTHER

Francis Gaskins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa Va

14

Informant (Address)

Mrs Alvinda Grover 5240 Main St

15

Filed

OCT 24 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/21 1922

17

I HEREBY CERTIFY, That I attended deceased from

10/9 1922, to 10/21 1922,

that I last saw him alive on 10/21 1922,

and that death occurred, on the date stated above, at 12.30 m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Respiratory paralysis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Symptomatic

(Signed)

Henry H. H. H. H.

M. D.

19 (Address)

8702 Grosvenor Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge Oct 24/22

20 UNDERTAKER

ADDRESS

A S Marshall 3539 Fall Rd.

MARGIN RESERVED FOR BIRMINGHAM
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. This is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68536

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D 68536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #142-Wilson-St.

ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Rachel Jane Rush

(a) RESIDENCE NO. #142-Wilson-St.

ST. 14 WARD (Resident)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ?

How long in U. S., if of foreign birth? 72 yrs. 3 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

(Single)

6 DATE OF BIRTH (month, day, and year) July-8-1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

3

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) Fallston, Harford Co Maryland (State or country)

10 NAME OF FATHER

Jacob Rush

11 BIRTHPLACE OF FATHER (city or town) Fallston Maryland (State or country)

12 MAIDEN NAME OF MOTHER

Eliza Tracy

13 BIRTHPLACE OF MOTHER (city or town) Md. Line, Maryland (State or country)

14

Informant The Misses Rush (sisters) (Address) 142-Wilson-St., City.

15

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27 1922

17

I HEREBY CERTIFY, That I attended deceased from 9-27, 1922, to 10-27, 1922,

that I last saw her alive on 10-20-1922,

and that death occurred, on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH* was as follows:

CARCINOMA OF UTERUS

(duration) 1 yrs. 2 mos. - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John F. Dorsey, M. D.

, 19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

LOUDON PARK CEMETERY

OCT-24-22

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

(WILLIAM F. WOODEN, Coroner)

103 W. NORTH AV.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68557

CERTIFICATE OF DEATH.

100-001 D 68557

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Derwart

(a) RESIDENCE NO. Unknown

ST. 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. ? About 44-45 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Boiler Maker
Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country) Baltimore Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Robert R. Krauter,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 19 22

17 I HEREBY CERTIFY, That I attended deceased from October 20, 19 22, to October 23, 19 22, that I last saw him alive on October 22, 19 22, and that death occurred, on the date stated above, at 4:35 A.M.
The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) 7 yrs. mos. ds.
CONTRIBUTORY Arterio Sclerosis
(Secondary) (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy
(Signed) Clyde H. Neill M. D.

10/20/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MO. AL
St. Marys Cross

DATE OF BURIAL

Oct 24 1922

20 UNDERTAKER

Wm Cook

ADDRESS

502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec. 1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68558

CERTIFICATE OF DEATH.

90 D 68558

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Fuchs

(a) RESIDENCE NO. Unknown
(Usual place of abode)

ST. 76 WARD

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 7 1842

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
80 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 ROBERT R. SAUER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 19 22

17

I HEREBY CERTIFY, That I attended deceased from October 20, 19 22 to October 22, 19 22, that I last saw him alive on October 21, 19 22, and that death occurred, on the date stated above, at 2:00 A.M.
The CAUSE OF DEATH* was as follows:

Senility

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 5 yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No - Refused

What test confirmed diagnosis?

(Signed) Clyde M. Neil M. D.

10/23/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR INTERMENT

DATE OF BURIAL

St. Bernard's Cemetery

20 UNDERTAKER

ADDRESS

William C. S. Rath

Filed Oct 24 1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68559

68559

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Hasselberg ST. 73 WARD)

2-FULL NAME

Katie Thompson

(a) RESIDENCE. NO.

416 Hasselberg ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

all life

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Thompson

6 DATE OF BIRTH (month, day, and year)

7 AGE 37 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md

10 NAME OF FATHER

John Blackstone

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Andrew Thompson 1116 Hasselberg St

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/22/22

17

I HEREBY CERTIFY, That I attended deceased from 9/9/22 to 10/22/22

that I last saw him alive on 10/22/22 at 3:30 p.m.

and that death occurred, on the date stated above, at 3:30 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

CONTRIBUTORY

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [Signature] M. D.

19 (Address) 905 5th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt Auburn Ct 10/24/22

20 UNDERTAKER ADDRESS

V. L. Thompson's Son 101 m Maily

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 24 1922

Burial Permit

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68560

CERTIFICATE OF DEATH.

D 68560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 S Green ST. 71 WARD)

2-FULL NAME

Vivian Powell

(a) RESIDENCE. NO.

703 S Green

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1919

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md

10 NAME OF FATHER

Joseph Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md

12 MAIDEN NAME OF MOTHER

Mary Sadler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md

14

Informant (Address)

Benjamin Powell 703 S Green

15

Filed 24 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/21/22

17

I HEREBY CERTIFY, That I attended deceased from

10/17/22

19

to

10/21/22

that I last saw him alive on

10/21/22

and that death occurred, on the date stated above, at 8:00 p. m.

The CAUSE OF DEATH* was as follows:

Brocho-pneumonia

CONTRIBUTORY (Secondary)

Whooping Cough about 3 mos. 4 ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

clinical

(Signed)

10/21/22

(Address)

908 S. Sharp St. J. H. Brown, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn C-

DATE OF BURIAL

Oct 24 1922

20 UNDERTAKER

J. H. Brown's Son

ADDRESS

108 W. Mt. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D68561

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68561

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Low Street ST. 5 WARD)

2-FULL NAME Sadie Rosenberg

(a) RESIDENCE NO. 909 Low Street ST. 5 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isidor Rosenberg

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE Years 38 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

10 NAME OF FATHER Isaac Rosenberg

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Eldy

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Jack Lewis (Address) 1439 E. Baltimore Street

15 Filed OCT 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-23-22

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1921, to Oct 23, 1922, that I last saw her alive on Oct 23, 1922, and that death occurred, on the date stated above, at 11:00 A.

The CAUSE OF DEATH* was as follows:

Cancer of Liver
Carcinoma of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard L. Extinger, M. D.

(Address) 1514 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 10/24 1922

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

968562

HEALTH DEPARTMENT—CITY OF BALTIMORE

968562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Home Aged Home

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 105

Quincy

ST.,

WARD)

2-FULL NAME

Sarah Beriman

(a) RESIDENCE NO.

1639 E. Pratt

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs.

mos.

ds. How long in U. S., if of foreign birth? 23 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Quinn Beriman

6 DATE OF BIRTH (month, day, and year)

1835

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

87

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

old age

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Russia

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

1337 E. Pratt St.

15

Filed

OCT 24 1922

ROBERT R. KRAUTER

Registrar

Burial Place: Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10-23-1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 21, 1922, to Oct 23, 1922.

that I last saw him alive on

Oct 23, 1922.

and that death occurred, on the date stated above, at

3 P. M.

The CAUSE OF DEATH* was as follows:

de dilatation of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Rehman Roadside

10/24/1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439

Pratt St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D68563		HEALTH DEPARTMENT—CITY OF BALTIMORE		D68563	
1-PLACE OF DEATH		CERTIFICATE OF DEATH.		Registered No. C.....	
City of BALTIMORE: (No.....)		South Baltimore General Hospital, 24th Ward		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
2-FULL NAME.....		George E. Hergert.		77 -- 2 -- 3.	
(Residence in Baltimore: No.....)		1039 Light Street.		St.; yrs..... mos..... ds.)	
PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.		
3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)	16-DATE OF DEATH.		
Male.	White.	Married.	October 20, 1922.		
6-DATE OF BIRTH.			(Month) (Day) (Year)		
August 17, 1845.					
7-AGE.			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.		
77 yrs. 2 mos. 3 ds.			The CAUSE OF DEATH* was as follows: Bacterial Pneumonia, impacted fracture of the head of femur. Shock. Automobile accident.		
8-OCCUPATION:			(Duration) yrs. mos. ds.		
(a) Trade, profession, or particular kind of work.....			CONTRIBUTORY (Secondary)		
Confectioner.			(Duration) yrs. mos. ds.		
(b) General nature of industry, business, or establishment in which employed (or employer).....			(Signed) Otto W. Reinhardt, M. D.		
9-BIRTHPLACE, (State or Country),			Oct. 23, 1922 (Address) 1017 E. Charles St.		
Baltimore Md.			*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
PARENTS.	10-NAME OF FATHER,	Edward C. Hergert.	18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).		
	11-BIRTHPLACE OF FATHER, (State or Country),	Germany.	At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.		
	12-MAIDEN NAME OF MOTHER,	Margaret E. Rodney.	Where was disease contracted, if not at place of death: Accident Hanover & Ostend Wis. October 15, 1922		
	13-BIRTHPLACE OF MOTHER, (State or Country),	Maryland.	Former or usual residence.....		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.			19-PLACE OF BURIAL OR REMOVAL.		
(Informant) Edward C. Hergert. (son).			London Park		
(Address) 233 Grindall Street.			DATE OF BURIAL.		
15. OCT 24 1922			Oct. 24 1922		
16. OCT 24 1922			20-UNDERTAKER.		
17. OCT 24 1922			John F. Denny		
18. OCT 24 1922			ADDRESS		
19. OCT 24 1922			715 Light St		

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *118-001* WARD)

2-FULL NAME

Louis A. McKenney(a) RESIDENCE. No. *909 Light* ST. *118-001* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

66

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

James McKenney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Phila. Pennsylvania

12 MAIDEN NAME OF MOTHER

Maria McDowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind. Ind.

14

Informant (Address)

St. Inc. Kenney 1039 Light St

OCT 24 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/23* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *October 22*, 19 *22*, to *October 23*, 19 *22*that I last saw him alive on *October 23*, 19 *22*and that death occurred, on the date stated above, at *4:15 P.M.*

The CAUSE OF DEATH* was as follows:

Strangulated right sided inguinal hernia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *10/22/22*Was there an autopsy? *No*What test confirmed diagnosis? *Spec. given*

(Signed)

Anthony V. Duckert, M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Louisa Park**Oct 26 1922*

20 UNDERTAKER

ADDRESS

*John H. Denny**715 Light St*N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68565		HEALTH DEPARTMENT—CITY OF BALTIMORE		268565	
PLACE OF DEATH		CERTIFICATE OF DEATH		161-001	
CITY OF BALTIMORE (No. 1619 Rutland Ave		ST. 8		WARD 8	
2-FULL NAME		Gilber Hands		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
(Residence in Baltimore: No. 1619 Rutland Ave		Sr.:		yrs. mos. ds.)	
PERSONAL AND STATISTICAL PARTICULARS					
3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)			
Male	White	Single			
6-DATE OF BIRTH					
May 23, 1922 (Month) (Day) (Year)					
7-AGE					
4 yrs. 28 mos. 28 ds. If LESS than 1 day, hrs. or min.?					
8-OCCUPATION					
(a) Trade, profession, or particular kind of work					
(b) General nature of industry, business, or establishment in which employed (or employer)					
9-BIRTHPLACE (State or country)					
Balto. Md					
10-NAME OF FATHER					
John E Hands					
11-BIRTHPLACE OF FATHER (State or country)					
Baltimore Md					
12-MAIDEN NAME OF MOTHER					
Edna G. Williams					
13-BIRTHPLACE OF MOTHER (State or country)					
Balto. Md					
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE					
(Informant) Mrs Edna G. Hands					
(Address) 1619 Rutland Ave					
15					
OCT 24 1922					
ROBERT R. KRAUTER, REGISTRAR					
Serial Permit					
MEDICAL CERTIFICATE OF DEATH					
16-DATE OF DEATH					
Oct 21, 1922 (Month) (Day) (Year)					
17-I HEREBY CERTIFY. That I attended deceased from					
Oct 10, 1922 to Oct 21, 1922					
that I saw him alive on Oct 21, 1922					
and that death occurred, on the date stated above, at 10 P. m.					
The CAUSE OF DEATH* was as follows:					
Acute pneumonia					
Contributory (SECONDARY)					
Malnutrition					
(Signed) J. A. H. M. D.					
10/23/22 (Address) 16 Rutland Ave					
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)					
At place of death yrs. mos. ds. In the State yrs. mos. ds.					
Where was disease contracted, If not at place of death?					
Former or usual residence					
19-PLACE OF BURIAL OR REMOVAL					
London Park					
DATE OF BURIAL					
Oct 24, 1922					
20-UNDERTAKER					
John H. Denny					
ADDRESS					
715 Light St					

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Womans Hospital

CITY OF BALTIMORE: (No.

ST., WARD)

2-FULL NAME

Magdalena Krausz
2703 Harwell

(a) RESIDENCE NO.

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

58 yrs. *1* mos. *16* ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX:

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chas F Krausz

6 DATE OF BIRTH (month, day, and year)

Aug 6 1864

7 AGE

Years

Months

Ds.

If LESS than 1 day, hrs. or min.

58

1

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Houses other

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Lorenz Fritz

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't know

14

Informant (Address)

Miss Minnie Krausz
2703 Harwell St

15

Filed *OCT 24 1922*

ROBERT R. SPALTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 22 1922

17

I HEREBY CERTIFY, That I attended deceased from *Oct 1*, 19 *22*, to *Oct 22*, 19 *22*.

that I last saw her alive on *Oct 22*, 19 *22*.

and that death occurred, on the date stated above, at *10 30* p. m.

The CAUSE OF DEATH* was as follows:

General peritonitis (streptococcus?)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Carcinoma of cervix

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Thomas T. Talbot* M. D.

. 19 (Address)

Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn

DATE OF BURIAL

Oct 25 1922

20 UNDERTAKER

John F. Denny

ADDRESS

715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T-1500 Bks.
D 68567
D 68567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 E. Chase ST., 8 WARD)

2-FULL NAME

Mary E. Tritel

(a) RESIDENCE No.

2222 E. Chase ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

5 yrs.

8 mos.

4 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm. E. B. Tritel

6 DATE OF BIRTH (month, day, and year)

Feb 12 - 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

8

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Edwin G. Brooke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Patience Grayman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant

Wm. E. B. Tritel

(Address)

2222 E. Chase St.

15

OCT 24 1922

ROBERT A. SAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

OCT 22 19 22

17

I HEREBY CERTIFY, That I attended deceased from Oct 20 19 22 to Oct 22 19 22

that I last saw her alive on Oct 21 19 22

and that death occurred, on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis
Myocardium

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) Fred R. Pugh, M.D.

1022 19 22 Address 800 N. Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmount Cemetery Oct 25 19 22

20 UNDERTAKER

Henry Lutz

ADDRESS

1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68568

CERTIFICATE OF DEATH.

968568
113 D 68568

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4401 Ready ave ST., 27 WARD)

2-FULL NAME Thomas A. Makiblin

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 4401 Ready ave
(Usual place of abode)

ST. WARD

Length of residence in city or town where death occurred

ys. 8 mos.

ds. How long in U. S., if of foreign birth?

ys. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 = 1922

7 AGE Years 8 Months 14 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Paul Makiblin

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country)

12 MAIDEN NAME OF MOTHER Anna Mennelly

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Mrs Makiblin (Address) 4401 Ready ave

15 Filed OCT 24 1922 ROBERT M. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1922

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1922, to Oct 22, 1922, that I last saw him alive on Oct 22, 1922

and that death occurred, on the date stated above, at 10.50 P. m. The CAUSE OF DEATH* was as follows:

Intestinal Decomposition
Marasmus

(duration) yrs. 4 mos. ds.

CONTRIBUTORY Artificial Feeding (Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Farley, M. D.

1913, 1922 (Address) 3502 Greenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Lorraine Cemetery Oct 24 1922

20 UNDERTAKER ADDRESS 203

Henry Lutz 20 Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. — 1-10-21 — MAT — 1500 Ills.

D 68569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Johns Hopkins Hospital*
CITY OF BALTIMORE: (No. *161-001* ST., *16* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Baby Smedley*

(a) RESIDENCE NO. *142/8 W. Lamble* ST., _____ WARD _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. *1* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *Oct 19/22*

7 AGE Years _____ Months _____ Days *1* If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) _____ (State or country) *Md.*

10 NAME OF FATHER *Bellford Smedley*

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) *Md.*

12 MAIDEN NAME OF MOTHER *Maria Schmitt*

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) *Md.*

14 Informant *W. W. Gray* (Address) *Johns Hopkins Hospital*

15 *OCT 24 1922*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 20 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 19th 1922* to *Oct 20th 1922*

that I last saw him alive on *Oct 20th 1922*

and that death occurred, on the date stated above, at *9:55 A. M.*

The CAUSE OF DEATH* was as follows:

Primaturity

(duration) yrs. mos. ds.

CONTRIBUTORY *Primatur Separation of* (Secondary) *Placenta*

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? *yes*

What test confirmed diagnosis? _____

(Signed) *W. W. Gray* M. D.

, 19 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *JOHNS HOPKINS HOSPITAL*

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Commissioner Health,

OCT 23 1922

Per. Wm. S. WOODALL

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Johns Hopkins Hospital

CITY OF BALTIMORE: (No.

ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Parks

(a) RESIDENCE NO.

837 Hollins

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

white

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 14 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

?

12 MAIDEN NAME OF MOTHER

Evelyn Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Johns Hopkins Hospital

JOHNS HOPKINS HOSPITAL

15

Filed

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

Commissioner Health,

FAC. W. E. WOODALL

DATE OF BURIAL

19

ADDRESS

OCT 23 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

968570

100-001 D 68570

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68571

CERTIFICATE OF DEATH

✓ D68571
90 D 68571

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *near 33rd St.*)

2-FULL NAME

(a) RESIDENCE. NO. *Hillier Road*

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Feb 26-1892*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

School Teacher

9 BIRTHPLACE (city or town) (State or country)

Washington D.C.

10 NAME OF FATHER

M. J. Naylor

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Calverto Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind.

14

Informant (Address)

Per M. J. Naylor Hillier Road

15

Filed OCT 24 1922

ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 22 1922*

17

HEREBY CERTIFY, That I attended deceased from

Oct. 1-1922, to Oct-20, 1922

that I last saw her alive on *Oct-20, 1922*

and that death occurred, on the date stated above, at *4 P* m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

CONTRIBUTORY (Secondary)

Exhaustion

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

Clinical

(Signed) *J. B. Hughes* M. D.

(Address) *1413 S. Hill St.*

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ind. Auburn

Oct 25 1922

20 UNDERTAKER

John H. Toadum

ADDRESS *1413 S. Hill St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 68572

HEALTH DEPARTMENT—CITY OF BALTIMORE

268572

CERTIFICATE OF DEATH.

74-001 D 68572

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 David Hill St.)

ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Eliza Stephenson

(a) RESIDENCE, No. 1622 David Hill St.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

caucasian

5 Single, Married, Widowed, or Divorced (write the word)

widowed

5a If married, widowed, or divorced, name of husband or wife of

6 DATE OF BIRTH (month, day, and year)

unknown

7 AGE

74

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

none

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md

10 NAME OF FATHER

don't no

11 BIRTHPLACE OF FATHER (city or town) (State or country)

don't no

12 MAIDEN NAME OF MOTHER

don't no

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

don't no

14

Informant

(Address)

mary stanley 423 n. joppa street

15

Filed

1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 2 1922, to Oct 23 1922,

that I last saw him alive on Sep 23 1922,

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) 3 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Whalley, M. D.

Address 1230 S. Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt duburn cemetery Oct 24 1922

20 UNDERTAKER

ADDRESS

John H. Toddman 1424 Hill St

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 24 179 268573 South Baltimore General Hospital. St. 24 Ward)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Earl F. Haynie.

(Residence in Baltimore: No. 1223 Wall Street. St.; yrs., 1 mos., 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Single (Write the word.)

6-DATE OF BIRTH.

July 3, 1921.

(Month) (Day) (Year)

7-AGE,

1 yrs., 3 mos., 20 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Baltimore Md.

PARENTS.

10-NAME OF FATHER,

William T. Haynie.

11-BIRTHPLACE OF FATHER, (State or Country).

Virginia.

12-MAIDEN NAME OF MOTHER,

Mabel E. Rebstock.

13-BIRTHPLACE OF MOTHER, (State or Country).

Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel Haynie. (mother).

(Address) 1223 Wall Street.

15-

Filed OCT 24 1922

19?

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

October 23, 1922.

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, au-

topsy or inquiry.) find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental burns about the body.

playing about a lighted gas oven.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. H. Reinhardt M. D.

(Coroner.) Oct. 23, 1922. (Address) 1517 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death Accident

1223 Wall St. Oct. 23, 1922.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill

10-26 1922

20-UNDERTAKER,

ADDRESS

E. B. Harb 115

E. B. Harb

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 N Lexington ST., 4 WARD)

2-FULL NAME

(a) RESIDENCE No. 746 N Lexington ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, write the word Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Reidingen

6 DATE OF BIRTH (month, day, and year) Dec 7 1850

7 AGE Years 71 Months 10 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Angsburg L. E. R. R. R. (Address) 746 N Lexington St.

15 Filed OCT 24 1922 Registrar LLG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922, to Oct 22, 1922, that I last saw him alive on Oct 20, 1922, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows:

acute Diastole

(duration) yrs. mos. ds. CONTRIBUTORY Chronic Right Disease (Secondary) of Kidneys (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Signed) G. Lohrke Esq. M. D.

(Address) 905 N. E. E. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL Western DATE OF BURIAL 10-24 1922

20 UNDERTAKER ADDRESS Mrs. Chas. A. G. Rold & Co. Arlington Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 FleetST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME JOSEPHINE V. FABISZAK,(a) RESIDENCE No. 1726 Fleet

(Usual place of abode)

ST., 2 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female, 4 COLOR OR RACE White, 5 Single, Married, Widowed, or Divorced, (write the word) Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17-1901.7 AGE Years Months Days If LESS than 1 day, hrs or min. 21 7 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) MD.10 NAME OF FATHER William Fabiszak,11 BIRTHPLACE OF FATHER (city or town) Poland, (State or country)12 MAIDEN NAME OF MOTHER Katharine Zubrowski,13 BIRTHPLACE OF MOTHER (city or town) Poland, (State or country)14 Informant William Fabiszak (Address) 1726 Fleet Street15 Filed Oct 24 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 22 Oct 192217 I HEREBY CERTIFY, That I attended deceased from 12 June, 1922, to 22 Oct, 1922, that I last saw him alive on 22 Oct, 1922, and that death occurred, on the date stated above, at 2:30 a.m. The CAUSE OF DEATH* was as follows:uremiaCONTRIBUTORY (Secondary) Chronic parenchymatous nephritis (duration) yrs. mos. 8 yrs.18 Where was disease contracted if not at place of death? noDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? urinalysis(Signed) W. J. M. D., 19 (Address) 3015 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Rosary Cem. DATE OF BURIAL Oct 25 1922.20 UNDERTAKER M. J. Sadowski ADDRESS 405 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 68576

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 68576)

JOHNS HOPKINS HOSPITAL.

ST., 2 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sophie Biele

(a) RESIDENCE NO.

604 S. Ann St

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 11 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Pete Backo

11 BIRTHPLACE OF FATHER (city or town)

Poland

(State or country)

12 MAIDEN NAME OF MOTHER

Annie Backo

13 BIRTHPLACE OF MOTHER (city or town)

Poland

(State or country)

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 23 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 12, 1922, to Oct 23, 1922.

that I last saw her alive on Oct 23, 1922.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery

over

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparie, M. D.

10/25/19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Stanislaus

DATE OF BURIAL

Oct 25 1922

UNDERTAKER

William Fialkowski 1618 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T 1800 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 68577 Municipal Hospital. ST. 21 WARD)

2-FULL NAME Mary Roche

(a) RESIDENCE NO. 1011 Starrett St.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO. 382 68577

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 54 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

10 NAME OF FATHER Geo. Seymore

11 BIRTHPLACE OF FATHER (city or town) Balto.,
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachael Hinds

13 BIRTHPLACE OF MOTHER (city or town) Balto.,
(State or country) Maryland

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed Oct 24 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 1922

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1922, to October 23, 1922.

that I last saw her alive on October 22, 1922.

and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Cerebro-spinal syphilis; syphilitic (duration) 25-30 yrs. mos. ds.

CONTRIBUTORY (Secondary) arthritis (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Refused

What test confirmed diagnosis? Wass. S-G; CSF.

(Signed) Chas. McNeil M. D.

10/23/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Western Cemetery

20 UNDERTAKER

James Dignan & Son

DATE OF BURIAL

Oct. 25 1922

ADDRESS

1000 S. Paca

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

968578 HEALTH DEPARTMENT—CITY OF BALTIMORE 968578

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1436 E. Fort Ave. ST. 24-3 WARD)

2-FULL NAME Harry J. Clark

(a) RESIDENCE NO. 1436 E. Fort Ave. ST. 24-3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1922

7 AGE Years Months Days If LESS than 1 day, / hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) Balto. Md.

10 NAME OF FATHER Harry J. Clark

11 BIRTHPLACE OF FATHER (city or town, State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER E. J. Wojciechowski

13 BIRTHPLACE OF MOTHER (city or town, State or country) Balto. Md.

14 Informant Harry Clark (Address) 1436 E. Fort Ave.

15 Filed 061241922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22, 1922

17 I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw him alive on 19 and that death occurred, on the date stated above, at 11:23 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum.

Duration - 1 hour (duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner M. D.

19 (Address) 1273 William St.

*State the Disease Causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cem

Oct 24 1922

20 UNDERTAKER

ADDRESS

Margaret J. Flynn 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

068579

HEALTH DEPARTMENT—CITY OF BALTIMORE

068579

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Aged Mens Home* ST. *19* WARD)

REGISTERED NO. *91-002*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James Condon*

(a) RESIDENCE. No. *1400 W Lexington* ST., WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *80* yrs. mos. ds.

How long in U. S., if of foreign birth? *80* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

W H

5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug 8, 1832*

7 AGE

Years

Months

Days

89

10

15

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Dublin Ireland*

10 NAME OF FATHER *Edward Condon*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Dublin Ir*

12 MAIDEN NAME OF MOTHER *Marjorie Wallace*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Dublin Ir*

14

Informant (Address) *H. W. Guilman*
Mabon

15

File

OCT 24 1922

ROBERT R. KRAUTER,
Burlal Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 23* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Oct 17, 19 *22*, to *Oct 23*, 19 *22*

that I last saw h..... alive on *Oct 23*, 19 *22*

and that death occurred, on the date stated above, at *11 30 P* m.

The CAUSE OF DEATH* was as follows:

General Atherosclerosis Heart & Arteries

(duration) *Unknown* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) *3* yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *No*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Arrowood*

(Signed) *Arrowood*, M. D.

Oct 17 19 *22* (Address) *939 W Fay St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

W Olive Cemetery *Oct 25 1922*

20 UNDERTAKER

ADDRESS *1000*

George J. Smith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 712 Arlingford St. (Swans) WARD 21)
2-FULL NAME Harry E. Seese
(a) RESIDENCE NO. 712 Arlingford St. ST. Swans WARD 21
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 33 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? 33 yrs. 8 mos. 25 ds.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Rose A. Seese
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Jan. 27 1889
7 AGE Years 33 Months 8 Days 25 If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Signal Maintainer
(b) General nature of industry, business, or establishment in which employed (or employer) Gen. R. R.
(c) Name of employer _____

9 BIRTHPLACE (city or town) Balti. (State or country) Md.

10 NAME OF FATHER Robert H. Seese

11 BIRTHPLACE OF FATHER (city or town) York Pa. (State or country) Pa.

12 MAIDEN NAME OF MOTHER Alice Lerow

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country) Md.

14 Informant Mrs. Rose A. Seese (Address) 712 Arlingford St.

15 OCT 24 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 22 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1912, 1922, to Oct. 22, 1922, that I last saw him alive on Oct. 21, 1922, and that death occurred, on the date stated above, at 5:30 P. m.
The CAUSE OF DEATH* was as follows:
Rupture of Aortic Artery
over

CONTRIBUTORY (Secondary) Anaerobic (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? No Date of _____

Was there an autopsy? No

What test confirmed diagnosis? X-ray
(Signed) George H. H. H. M. D.
Address 101 E 15th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Woodlawn Cemetery DATE OF BURIAL Oct 25 1922

20 UNDERTAKER Henry Zwick Sen ADDRESS 1301 E Eager St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 6-9-19—H. P. Co.—1000 Bks.

68581

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

68581

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 139 N Pauline ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 139 N Pauline ST. 23 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Amelia Marshall

6 DATE OF BIRTH (month, day, and year)

April 1, 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Steam Pipe Fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Geo W Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Catharine Bayne

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14 Informant (Address)

Mrs Marshall 139 N Pauline

15 OCT 24 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 22 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to Oct 22, 1922, that I last saw him alive on Oct 22, 1922.

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture

(Signed) H. E. Campbell M. D.
Oct 22, 1922 (Address) 1644 Hancock St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill Cemetery

Oct 24 1922

20 UNDERTAKER

E. O. Fanning & Son - 1465 Battery Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68683

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68683

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Hospital ST. 2 WARD)

2-FULL NAME

Dr. William Blackwell

(a) RESIDENCE NO.

3 York St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE 37 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

10 NAME OF FATHER Wm Blackwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) M. C.

12 MAIDEN NAME OF MOTHER Lucy Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) M. C.

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 19 1922

17

I HEREBY CERTIFY, That I attended deceased from October 10, 1922, to October 19, 1922.

that I last saw him alive on October 19, 1922.

and that death occurred, on the date stated above, at 12:09 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Connors, M. D.

19 (Address) South Baltimore Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNIVERSITY OF MARYLAND.

UNDERTAKER Commissioner Health,

ADDRESS OCT 24 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Volunteers of America Hospital* ST. *15* WARD)2-FULL NAME *John W. Shepherd*(a) RESIDENCE. NO. *22 Cedar ave, Curtis Bay* ST. *Bay* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *m*4 COLOR OR RACE *w*5 Single, Married, Widowed,
or Divorced (write the word)
*married*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of *?*6 DATE OF BIRTH (month, day, and year) *?*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.
71

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work *?*(b) General nature of industry,
business, or establishment in
which employed (or employer) *?*(c) Name of employer *?*9 BIRTHPLACE (city or town)
(State or country) *?*10 NAME OF FATHER *?*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *?*12 MAIDEN NAME OF MOTHER *?*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *?*

14

Informant
(Address)

15

Filed

OCT 24 1922

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk,

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 16 1922*

17

I HEREBY CERTIFY, That I attended deceased from
Sept 21, 1922, to *Oct 16*, 1922,
that I last saw him alive on *Oct 16*, 1922,
and that death occurred, on the date stated above, at *6.30 a.m.*

The CAUSE OF DEATH* was as follows:

Nephritis(duration) *2* yrs. *2* mos. *5* ds.CONTRIBUTORY
(Secondary) *Chorea*(duration) *5* yrs. *5* mos. *5* ds.18 Where was disease contracted
if not at place of death? *?*Did an operation precede death? *no* Date of *no*Was there an autopsy? *no*What test confirmed diagnosis? *Albumen test*
(Signed) *Albert J. Conroy*, M. D.19 (Address) *Volunteers of A. Hospital**State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health,

Wm. F. WOODALL

OCT 24 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE		
CERTIFICATE OF DEATH.		
1-PLACE OF DEATH City of BALTIMORE: (No. <u>35 W. Cross Street.</u> St., <u>23</u> Ward)		Registered No. C.....
2-FULL NAME..... <u>Charles Hughes. (C).</u>		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. <u>35 W. Cross Street.</u> St.; yrs., mos., ds.)		
PERSONAL AND STATISTICAL PARTICULARS.		
3-SEX. <u>Male.</u>	4-COLOR OR RACE. <u>Colored.</u>	5-Single, Married, Widowed, or Divorced. <u>Single.</u> (Write the word.)
6-DATE OF BIRTH. <u>Do not know.</u> (Month) (Day) (Year)		
7-AGE. <u>35</u> yrs. --- mos. --- ds.		If LESS than 1 day. ... hrs. or ... min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work..... <u>Laborer.</u> (b) General nature of industry, business, or establishment in which employed (or employer).....		
9-BIRTHPLACE. (State or Country), <u>Norfolk Va.</u>		
PARENTS.	10-NAME OF FATHER, <u>Do not know.</u>	
	11-BIRTHPLACE OF FATHER, (State or Country), <u>Do not know.</u>	
	12-MAIDEN NAME OF MOTHER, <u>Do not know.</u>	
	13-BIRTHPLACE OF MOTHER, (State or Country), <u>Do not know.</u>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <u>Police Report.</u> (Address).....		
15- FILED <u>OCT 24 1922</u> <u>ROBERT R. KRAUTER,</u> <u>Burial Permit Clerk.</u>		
CORONER'S CERTIFICATE OF DEATH.		
16-DATE OF DEATH, <u>October 14th, 1922.</u> (Month) (Day) (Year)		
17- I HEREBY CERTIFY, That, I took charge of the remains described above, held an <u>inquiry</u> (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said <u>inquiry</u> and that said deceased came to <u>his</u> death (Inquest, autopsy or Inquiry.) on the day stated above. The CAUSE OF DEATH* was as follows: <u>Pulmonary Tuberculosis.</u> (Duration) yrs. mos. ds.		
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) <u>W. M. Pennington</u> M. D. (Coroner) <u>Oct. 19, 1922</u> (Address) <u>1017 E. Charles St.</u>		
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.		
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?.....		
Former or usual residence.....		
19-PLACE OF BURIAL OR REMOVAL, <u>CITY OF MARYLAND</u>		DATE OF BURIAL, <u>Oct 24 1922</u>
20-UNDERTAKER, <u>Commissioner Health,</u>		ADDRESS <u>412</u>

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *121 McTavish Ave* ST. *25* WARD)2-FULL NAME *Catherine C. Bonarigo*(a) RESIDENCE. No. *121 McTavish Ave* ST. *25* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *15* yrs. — mos. ds. How long in U. S. If of foreign birth? *15* yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Kunzio Bonarigo*

6 DATE OF BIRTH (month, day, and year)

March 1888

7 AGE

34 Years*6* Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*Housework.*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Italy*

10 NAME OF FATHER

*Frank Schepis*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Italy*

12 MAIDEN NAME OF MOTHER

*Camela Bonariga*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Italy*

14

Informant
(Address)*Kunzio Bonarigo*
121 McTavish Ave

15

OCT 24 1922

ROBERT R. KRAUTER
Registrar

Burial Permit Clerk

Bonarigo ✓

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 23* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from
May 19 *20*, to *Oct 23*, 19 *22*,that I last saw him alive on *Oct 22*, 19 *22*,and that death occurred, on the date stated above, at *5 a.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Bronchial asthma*

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?*?*Did an operation precede death? *no* Date of *✓*Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed)

Reginald Dill M. D.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cem.

DATE OF BURIAL

Oct. 25 19 *22*

20 UNDERTAKER

B. W. Dill

ADDRESS

*3109
Fredk. Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

068587

068587

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. *St. Joseph's Hospital* St. *8* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Joseph P. Farren*

(Residence in Baltimore: No. *1600 E. Chase St* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH, *March 20* 1890 (Month) (Day) (Year)

7-AGE, *32* yrs. *7* mos. *1* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Auto* (b) General nature of industry, business, or establishment in which employed (or employer). *Machinist*

9-BIRTHPLACE, (State or Country). *Md.*

10-NAME OF FATHER, *John P. J. Farren*

11-BIRTHPLACE OF FATHER, (State or Country). *Ireland*

12-MAIDEN NAME OF MOTHER, *Winifred Toher*

13-BIRTHPLACE OF MOTHER, (State or Country). *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Winifred Farren*

(Address) *1600 E. Chase St*

15-

Filed *1922* *ROBERT R. KRAUTER* Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *October 21* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull - Cerebral Hemorrhage
Auto mobile accident
Belted (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. P. Farren* M. D. (Coroner.)

1612 3rd St. (Address) *508 E. Pratt St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Holy Redeemer Center *Oct 26* 1922

20-UNDERTAKER, ADDRESS

George J. Routh *1335 Hayford Ave.*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 Birchwood Av ST. 37 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME May Marcella Johnston

(Residence in Baltimore: No. 206 Birchwood Av St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH, October 7, 1922 (Month) (Day) (Year)

7-AGE, 16 yrs. 16 mos. 16 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Child (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Ind.

PARENTS. 10-NAME OF FATHER, R. J. Marcella Johnston 11-BIRTHPLACE OF FATHER (State or Country), Balto. Ind. 12-MAIDEN NAME OF MOTHER, Marie F. Miller 13-BIRTHPLACE OF MOTHER (State or Country), Balto. Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert J. Marcella Johnston (Address) 206 Birchwood Av

15- Filed 1922 16-ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 10 / 23 / 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 7 1922, to Oct 23 1922, that I saw her alive on Oct 23 1922, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Pneumonia

bordered ventilation (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY Pulmonary edema (Secondary)

(Signed) Clara M. D. 10/24/22, 1922 (Address) 4257 Hampden

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS). At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cemetery DATE OF BURIAL, 10.25.1922

20-UNDERTAKER George J. Ruth ADDRESS 1735 Hayford Av.

7. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Ve 2700
Spec. 6-9-11—H. P. Co.—1000 Bks.

DL. 68589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

DL. 68589

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Med. Gen Hospital*)

ST.: *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: *Charles Bernard Reese*

(a) RESIDENCE. No. *1019 Stewart St*

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Marie Florence Hallen*

6 DATE OF BIRTH (month, day, and year) *Sept 15, 1892*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *30*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) *Mrs. Nellie Reese 728 S. Peter St.*

15 Filed *Robert P. Harrison*

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/23* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *9/27/22* 19 to *10/23/22* 19

that I last saw him alive on *10/23/22* 19

and that death occurred, on the date stated above, at *2:50* p.m.

The CAUSE OF DEATH* was as follows:

Nephrotic uraemia

(duration) *10* yrs. mos. ds. CONTRIBUTORY (Secondary) *Spiral Fracture*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *about 1912*

Was there an autopsy? *Yes*

What test confirmed diagnosis? *Chemical & Anatomical*

(Signed) *W. J. Harrison* M. D.

, 19 (Address) *1019 Stewart St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Oliver Cemetery

Oct. 26, 1922

20 UNDERTAKER

ADDRESS

John J. Cowan & Son 901 Hollander St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.68590 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68590

1-PLACE OF DEATH

City of BALTIMORE: (No. 938 N. Schick St. 16 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 938 N. Schick St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH, 7-AGE, If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant: Daniel Easton)

(Address: 916 Penn. Ave.)

15- Robert P. Harrison,

Filed 1922 Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

organic heart disease

CONTRIBUTORY (Secondary) history

(Signed) J. T. Hennessey, M. D. (Coroner.) 280 Remond Ave. 1922

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

20-UNDERTAKER, ADDRESS

Daniel Easton 916 Pe

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68591

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Josephine ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William H. Grader

(a) RESIDENCE NO.

634 Josephine ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

7 yrs.

— mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June? 1879

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

434—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

W. Hays

9 BIRTHPLACE (city or town) (State or country)

Richmond

10 NAME OF FATHER

Benjamin D. Grader

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Richmond

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Frank Cornish
634 Josephine St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/21/ 19 22

17

I HEREBY CERTIFY, that I attended deceased from Oct 20 19 22 to Oct 21 19 22that I last saw him alive on Oct 21 19 22and that death occurred, on the date stated above, at 10:50 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Disease

CONTRIBUTORY (Secondary)

(duration) Indefinite mos. ds.(duration) Indefinite mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Fowler M. D.10/21/1922 (Address) 119 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

20 UNDERTAKER

Richmond
Wm. Taylor

DATE OF BURIAL

Oct 25 19 22

ADDRESS

916

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 24 1922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Probably Syphilis

D. 68592 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68592

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 6 Monument

ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Menaker.

(a) RESIDENCE. NO.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-23-22

7 AGE

Years

Months

Days

If LESS than 1 day, 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Jacob Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Dolma Friedman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jacob Friedman 8298. Park St

15

Filed

Oct 24 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-24 1922

17

I HEREBY CERTIFY, That I attended deceased from

10-23, 1922, to 10-24, 1922.

that I last saw her alive on 10-24, 1922.

and that death occurred, on the date stated above, at 11⁰⁰ a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration)

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Ernest Edvardson, M. D.

10-24, 1922 Address)

Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

At Hebrew Hospital

10/24/22

20 UNDERTAKER

ADDRESS

May Lerner 2 Balto. St.

DL. 68593

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL. 68593

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

814 n wolfe

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph Poledna

(a) RESIDENCE. NO.

814 n wolfe

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

30 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

male

white

married

5a If unmarried, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, year)

Sept 23 1869

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bohemia

10 NAME OF FATHER

John Poledna

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

14 Informant (Address)

John Poledna 814 n wolfe st

15 Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 23

1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 23

1922, to

Oct 23

1922

that I last saw him alive on

Oct 23

1922

and that death occurred, on the date stated above, at

10:40 P. m.

The CAUSE OF DEATH* was as follows:

mitral insufficiency

6 wks

(duration)

0 yrs.

1 mos.

15 ds.

CONTRIBUTORY (Secondary)

Cardiac Dropsy

6 wks

(duration)

0 yrs.

1 mos.

15 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

J. Edward Fisher

M. D.

19

(Address)

1612 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Oct 26 1922

20 UNDERTAKER

ADDRESS

Lambert & Co

1906 Baltimore

Burial Permit Clerk.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OCT 24 1922

(Krabak)
 10.68594 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68594

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Hazel

ST.: 75 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 105 Hazel st

St.: 35 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male	4-COLOR OR RACE White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH. Oct 4, 1869 (Month) (Day) (Year)		
7-AGE, 53 yrs., mos., ds.		It LESS than 1 day, ... hrs. or ... min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Carpenter Car-Building		
9-BIRTHPLACE, (State or Country), Bohemia		
PARENTS.	10-NAME OF FATHER, Joseph Krabak	
	11-BIRTHPLACE OF FATHER (State or Country), Bohemia	
	12-MAIDEN NAME OF MOTHER M. Brown	
	13-BIRTHPLACE OF MOTHER (State or Country), Bohemia	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Robert P. Harrison,

191

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Aug 30, 191, to Oct 23, 191,

that I saw him alive on Oct 23, 191,

and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the stomach

(Duration) yrs., mos., ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs., mos., ds.

(Signed) William H. Harrison, M. D.

Oct 24, 191, (Address) 811 N. ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Cedar Hill

Oct 27, 191

20-UNDERTAKER

ADDRESS

Frank Brackdon

1000 ...

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1922
 T241922

10.68595 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68595

159-003

1-PLACE OF DEATH

City of BALTIMORE: (No. 511 N. Biddle St. 17 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Thomas

(Residence in Baltimore: No. 511 N. Biddle St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE colored 5-Single, Married, Widowed, or Divorced. Single

6-DATE OF BIRTH Oct. 21, 1922 (Month) (Day) (Year)

7-AGE yrs. mos. ds. If LESS than 1 day, 5 hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country) Balto. Md.

10-NAME OF FATHER Mrs. Campbell

11-BIRTHPLACE OF FATHER Md.

12-MAIDEN NAME OF MOTHER Mary Thomas

13-BIRTHPLACE OF MOTHER Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Walter Taylor (Address) 511 N. Biddle St.

15- Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Oct. 22, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry. thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows: Patent foramen ovale

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. T. Harrison, M. D. (Coroner) Oct. 22, 1922 (Address) 270 E. Lombard St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

20-UNDERTAKER ADDRESS

D.68596 HEALTH DEPARTMENT—CITY OF BALTIMORE D.68596

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Arch ST.; 47 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 111 Arch St.; 5 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

Colored

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

Unknown, 1872

7-AGE,

50 yrs., mos., ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Cook, State University

9-BIRTHPLACE, (State or Country),

Woodstock VA

10-NAME OF FATHER,

James H Brown

11-BIRTHPLACE OF FATHER (State or Country),

VA

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mack Clay

(Address) 111 N. Arch St.

15-

Filed

Robert P. Harrison,

191

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 22, 1912

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 15, 1912, to Oct 22, 1912

that I saw her alive on Oct 22, 1912

and that death occurred, on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 7 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) Henry H. Weinsticker, M. D.

Oct 24, 1912 (Address) 724 W. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Unknown

Oct 23, 1912

20-UNDERTAKER

ADDRESS

James H. Weinsticker

M. D.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

20.68597

20.68597

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1905 Brunt ST. 14 WARD)

REGISTERED No. C _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Francis General Canell(Residence in Baltimore: No. 1905 Brunt St. St. 8 yrs., _____ mos., _____ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female4-COLOR OR RACE. Caucasian5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)6-DATE OF BIRTH. Oct 14, 1903

(Month) (Day) (Year)

7-AGE. 19 yrs., 6 mos., _____ ds.

If LESS than 1 day, _____ hrs. or _____ min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Frederick Co. Md.10-NAME OF FATHER, Walter T. Chapman11-BIRTHPLACE OF FATHER (State or Country), St Mary's Co. Md.12-MAIDEN NAME OF MOTHER Ethel Duggs13-BIRTHPLACE OF MOTHER (State or Country), Frederick Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matthews Canell(Address) 1905-Brunt St.

15-

Filed _____ 191 _____ Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 22, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from October 16 1912, to Oct 22 1922, that I saw her alive on Oct-21 1922, and that death occurred, on the date stated above, at 5-P m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
(Duration) _____ yrs., _____ mos., _____ ds.

CONTRIBUTORY (Secondary)

(Duration) _____ yrs., _____ mos., _____ ds.

(Signed) M. E. Daugherty M. D.Oct 23, 1922 (Address) 1662 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death _____ yrs., _____ mos., _____ ds. In the State _____ yrs., _____ mos., _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19-PLACE OF BURIAL OR REMOVAL, St. Ambrose DATE OF BURIAL, Oct 23, 192220-UNDERTAKER, James M. Gensley ADDRESS _____

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

OCT 24 1922

D 68598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D 68598

PLACE OF DEATH

CITY OF BALTIMORE (No. *John Hopkins Hosp*)FULL NAME *Lillian Wainless*(Residence in Baltimore: No. *257 Eder st*)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *5* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *white* 5-SINGLE, *single* MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

(Month) (Day) (Year) *1*7-AGE, *26*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *None*
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE, (State or Country), *Russia*

PARENTS.

10-NAME OF FATHER, *Perel Lesnover*11-BIRTHPLACE OF FATHER (State or Country), *Russia*12-MAIDEN NAME OF MOTHER *Jacob Lesnover*13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mat Wainless*(Address) *1735 Fairmount Ave*

15. OCT 25 1922

Filed

ROBERT R. KRAUTER,

101

Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 23, 1922*

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.)And that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull -
Cerebral Hemorrhage
Accidental
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. P. P. P.* M. D.

(Coroner.)

10-24, 1917. (Address) *1086 N. Mt. Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Abraham Hamming Bur*DATE OF BURIAL, *10/25, 1922*20-UNDERTAKER *J. Shinsor + Co*ADDRESS *1127 E. Belto St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68599

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68599

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *27* ST. *27* WARD)

2-FULL NAME

(Residence in Baltimore: No. *12 Lewiston Ave*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
6-DATE OF BIRTH, *Sept 12*, 18*74*
(Month) (Day) (Year)

7-AGE, *48* yrs. *1* mos. *10* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Immigrant in shirt factory*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *England*

10-NAME OF FATHER, *Hugh Collins*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER *Catherine Hester*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Harry M. Collins*

(Address) *12 Lewiston Ave*

15- *OCT 25 1922* *ROBERT R. KRAUTER,*

Filed *191* *Burial Permitted*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 22nd*, 19*22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal result of accident
Accidental fall from steps
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *Harry M. Collins* M. D.

(Coroner.)

Oct 23, 19*22* (Address) *12 Lewiston Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death...yrs...mos...ds. In the State...yrs...mos...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *St Peters* DATE OF BURIAL, *Oct 26*, 19*22*

20-UNDERTAKER *Robt Turner* ADDRESS *442 M Broadway*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1 10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68600

D 68600

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3463 Hickory Ave ST. 13 WARD)

2-FULL NAME

John H. Slemaker

(a) RESIDENCE NO.

3463 Hickory Ave

WARD

(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Josephine Slemaker

6 DATE OF BIRTH (month, day, and year) Feb 7 1842

7 AGE 80 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

John H. Slemaker

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14 Informant (Name and Address) John H. Slemaker Jr
912 N. Holliston

15 Filed OCT 25 1922 ROBERT R. KRAUTER Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 19 22

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 22, to Oct 23, 19 22; that I last saw him alive on Oct 23, 19 22, and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Dropped

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

same

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Ex of urine - slow pulse - clinical signs

(Signed)

Vermon F. Kelly, M. D.

1922 (Address)

3705 Fair Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cedar Hill Cem Oct 26 19 22

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut

D 68601

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68601

159-003

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3813 Falls Road ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret F. Spencer

(a) RESIDENCE. No. 3813 Falls Road ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 18, 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

10 NAME OF FATHER Benjamin Spencer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Mildred M. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) La Grange, N. C.

14 Informant Benjamin Spencer (Address) 3813 Falls Road

15 Filed OCT 25 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 24 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1922, to Oct. 24, 1922, that I last saw her alive on Oct. 24, 1922, and that death occurred, on the date stated above, at 6 P. m. The CAUSE OF DEATH* was as follows:

Eclampsia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Machin, M. D.

19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Westminster 9th Oct 25 1922

20 UNDERTAKER ADDRESS

Chenoweth & Son Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Congenital Malformation
of Stomach*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68602

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 68602

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes' Hospital* ST. *13* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mr. Adam Herbert*

(a) RESIDENCE NO. *Boonville Md* ST. _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred *61* yrs. *1* mos. *1* ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? *1* yrs. *1* mos. *1* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Mrs. Annie Herbert*

6 DATE OF BIRTH (month, day, and year) *Jan. 6 1861*

7 AGE *61* Years Months Days If LESS than 1 day, hrs. or min. *Don't know*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Md*

10 NAME OF FATHER *Do not know*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*

12 MAIDEN NAME OF MOTHER *Do not know*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*

14 Informant *Mrs. Annie Herbert* (Address) *Boonville Md*

15 *Oct 25 1922* *ROBERT H. KRAUTER,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 23 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct. 8 1922* to *Oct. 23 1922*

that I last saw him alive on *Oct 23 1922*

and that death occurred, on the date stated above, at *3:14 p.m.*

The CAUSE OF DEATH* was as follows:

Apothecary

(duration) yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary) *Broncho pneumonia*

(duration) yrs. *3* mos. *3* ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *No* Date of _____

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*

(Signed) *W.C. Caldwell*, M. D.

, 19 (Address) *St. Agnes Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Druid Ridge Cemetery*

DATE OF BURIAL *Oct 27 1922*

20 UNDERTAKER *Henry Hoch Sul*

ADDRESS *1301 E. Gay St*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D 68603

PLACE OF DEATH

CITY OF BALTIMORE (No.

2331 Strand Hill Ave. ST. 13

WARD)

2-FULL NAME

Belia Silverman

(Residence in Baltimore: No.

2331 Strand Hill Ave

St.; yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female white

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Unknown, 1868 (Month) (Day) (Year)

7-AGE,

54

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE, (State or Country),

Russia

10-NAME OF FATHER,

A. L. Cheslock

11-BIRTHPLACE OF FATHER (State or Country),

Russia

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Jack Lewis

(Address)

1439 E. B. Calhoun

15-

OCT 25 1922

ROBERT R. MAUTER,

Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

10-24, 1922 (Month) (Day) (Year)

17-

I HEREBY CERTIFY THAT I took charge of the

remains described above, held an inquest, autopsy or inquiry,

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary disease of heart (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Harrison, M. D. (Coroner.)

(Address) 3022 Rolfe

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL,

Nehrens Wash Rd. 10/25, 1922

20-UNDERTAKER

ADDRESS

Jack Lewis 1439 E. B. Calhoun

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68604 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68604

1-PLACE OF DEATH

City of BALTIMORE: (No. Montgomery St. near Warner St. Ward 22)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John T. Moore, C.

(Residence in Baltimore: No. 824 S. Sharp St. St.; yrs. 11 mos. ----- ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male, 4-COLOR OR RACE, Colored, 5-Single, Married, Widowed, or Divorced, Married.
(Write the word.)

6-DATE OF BIRTH, June 17th, 1894, 1.....
(Month) (Day) (Year)

7-AGE, 28 yrs. 4 mos. 4 ds., If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Virginia.

PARENTS.
10-NAME OF FATHER, Albert Moore, C.
11-BIRTHPLACE OF FATHER, (State or Country), Virginia.
12-MAIDEN NAME OF MOTHER, Bettie Ritchie, C.
13-BIRTHPLACE OF MOTHER, (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William H. Moore, C. (brother)

(Address) 824 S. Sharp St.

15- OCT 25 1922 ROBERT R. KRAUTER,
FILED 1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21st, 1922, 1922.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:
Intra crainial hemorrhage and laceration of the brain, due to a pistol shot wound. Homicide.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ----- (Duration) yrs. mos. ds.
(Signed) W. H. Reinhardt M. D. (Coroner.)
1922 (Address) -----

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, King of Queen Co Va, DATE OF BURIAL, Oct 25, 1922

20-UNDERTAKER, L. B. Brown & Son, ADDRESS, 108 W. Montgomery

by way of Chesapeake & S. Line to Saint Point Va

N. B. — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68605

CERTIFICATE OF DEATH.

D 68605

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1454 Wilconia ST., 21 WARD)

2-FULL NAME

(a) RESIDENCE No. 1454 Wilconia ST.,

(Usual place of abode)

Length of residence in city or town where death occurred

1 yr.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Oct 25 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

10/24/22, 19 to 10/23/22, 19 that I last saw him live on 10/23/22, 19

and that death occurred, on the date stated above, at 3:39 m.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68606

CERTIFICATE OF DEATH.

D 68606

1-PLACE OF DEATH

Howard H. Kelly Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

1418 Eutaw St.

ST.:

WARD)

2-FULL NAME

Mr. Sol. Neuham

(a) RESIDENCE. NO.

Marlborough Apts

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Lifetime

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 3, 1864.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

3

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

Traveling Salesman

(c) Name of employer

L. Giff & Bros.

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Samuel Neuham

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Regina Copenhagen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Klein Castle

14

Informant (Address)

Mrs. L. Frank Marlborough Apts.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 24 1922

17

I HEREBY CERTIFY, That I attended deceased from

Apr 4, 1919, to Oct 24, 1922

that I last saw him alive on Oct 24, 1922

and that death occurred, on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of cheek - rt

(duration) 3 yrs. 6 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Residence

Did an operation precede death? yes Date of May 1 '22

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam of

(Signed) Grant Edward, M. D.

19 (Address) 1418 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Friendship Cem

10/27/1922

20 UNDERTAKER

David Sandheim

ADDRESS 118 20th St Royal Ave

OCT 25 1922

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Rhs.

D 68607 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68607

1-PLACE OF DEATH *Homewood Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. *27* WARD)

2-FULL NAME *Oland Cavallaro*

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct. 23-1922

7 AGE

Years

Months

Days

If LESS than 1 day 24 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

Luigi Cavallaro

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Anna M. Russo

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Hospital Records

15

Filed

Oct 25 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 23* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 22* 19 *22*, to *Oct 23* 19 *22*.

that I last saw him alive on *Oct 23* 19 *22*.

and that death occurred, on the date stated above, at *5 P.M.* m.

The CAUSE OF DEATH* was as follows:

non closure of foramen ovale

(duration) *7* yrs. *1* mos. *1* ds.

CONTRIBUTORY (Secondary)

(duration) *7* yrs. *1* mos. *1* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Stephen J. Stillman* M. D.

, 19 (Address) *1227 Maryland Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

St. Vincent's

DATE OF BURIAL

Oct 25 1922

20 UNDERTAKER

Wendel Kippel & Son

ADDRESS

571 Avenue

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68608

CERTIFICATE OF DEATH.

D 68608

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3925 Trisky St. ST.; 9 WARD)

2-FULL NAME Molly E. Creamer

(Residence in Baltimore: No. 3925 Trisky St. St.; 9 WARD mos. ds)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female white

4-COLOR OR RACE,

5-SINGLE, ^{widow}
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Sept. 27, 1847
(Month) (Day) (Year)

7-AGE,

75 yrs. 27 ds.

If LESS than 1 day,
....hrs. or....min.

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, busi-
ness, or establishment in which
employed (or employer).

House Work

9-BIRTHPLACE,
(State or Country),

Balto. Md.

10-NAME OF
FATHER,

Livingston Bennett

11-BIRTHPLACE
OF FATHER
(State or Country),

Balto. Md.

12-MAIDEN NAME
OF MOTHER

Eva Yundt

13-BIRTHPLACE
OF MOTHER
(State or Country),

Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Grace E. Rudd

(Address)

1624 St. Paul St.

15-

Filed OCT 25 1922

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Oct 24, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 2 1922, to Oct 24 1922,

that I saw him alive on Oct 23 1922

and that death occurred, on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows:

Intermittent
Chronic Intestinal nephritis
Chronic Myocarditis

(Duration) 10 yrs. 10 mos. 27 ds.

CONTRIBUTORY
(Secondary)

(Duration) 10 yrs. 10 mos. 27 ds.

(Signed) S. D. Bishop M. D.

Oct 24, 1922 (Address) 501 S. Hendon Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 2 yrs. 10 mos. 27 ds. In the State 10 yrs. 10 mos. 27 ds.

Where was disease contracted, if not at place of death? 918 Selma St

Former or usual residence 918 Selma St

19-PLACE OF BURIAL OR REMOVAL,

Greenmount Cem.

DATE OF BURIAL,

Oct 26, 1922

20-UNDERTAKER

Wm Cooly

ADDRESS

502 E. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68609

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 Richmond

ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Thomas Wooden

(a) RESIDENCE NO.

304 Richmond

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Elizabeth Wooden

6 DATE OF BIRTH (month, day, and year)

Oct 12, 1870

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

52

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Resturant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

Balto

(State or country)

10 NAME OF FATHER

Henry Wooden

11 BIRTHPLACE OF FATHER (city or town)

Balto

(State or country)

12 MAIDEN NAME OF MOTHER

Wilhelmina Singer

13 BIRTHPLACE OF MOTHER (city or town)

Germany

(State or country)

14

Informant (Address)

Elizabeth Wooden
304 Richmond

15

Filed

Oct 25, 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25, 1922

17

I HEREBY CERTIFY, That I attended deceased from

1922, to Oct 25, 1922.

that I last saw him alive on

Oct 25, 1922.

and that death occurred, on the date stated above, at 11-15 P.M.

The CAUSE OF DEATH* was as follows:

cirrhosis of the liver

(duration) yrs. 4 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Boyer M. D.

19-22, 1922 (Address) 604 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer

DATE OF BURIAL

Oct 26, 1922

20 UNDERTAKER

John V. Vellrich

ADDRESS

2008 Orleans

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Alcoholic

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68610

D 68610

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1144 Washington Blvd* ST. *1* WARD)

2-FULL NAME

Sarah Birmingham

(a) RESIDENCE No.

1144 Washington Blvd ST. *1* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *24* yrs. *50* mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Birmingham

6 DATE OF BIRTH (month, day, and year)

Nov 97 1844

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*77**11**8*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Larkin Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Margaret Holley 1144 Wash. Blvd

15

Filed *25 1922*

ROBERT R. KRAUTER, Registrar

Burial Permit *1156 Washington Blvd.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 24 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 1*, 19*22*, to *Oct 24*, 19*22*that I last saw him alive on *Oct 23*, 19*22*and that death occurred, on the date stated above, at *2 a* m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation(duration) *4* yrs. *0* mos. *0* ds.

CONTRIBUTORY (Secondary)

(duration) *0* yrs. *0* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Dr. M. Kieffer* M. D.*Oct 25, 1922* (Address) *2320 Marl Blvd*

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

St. Olives

DATE OF BURIAL

10/27/22

20 UNDERTAKER

Bernard H. Fink

ADDRESS

1156 Washington Blvd.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola, Hogg(a) RESIDENCE NO. 937 2nd St Canton WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredrick Hogg6 DATE OF BIRTH (month, day, and year) Nov 24 - 18987 AGE Years 23 Months " Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)10 NAME OF FATHER Jacob Franklin11 BIRTHPLACE OF FATHER (city or town) Pa (State or country)12 MAIDEN NAME OF MOTHER Johanna Strunk13 BIRTHPLACE OF MOTHER (city or town) Pa (State or country)14 Informant W. W. Gray Johns Hopkins Hospital. (Address)15 OCT 25 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 192217 I HEREBY CERTIFY, That I attended deceased from Oct 22, 1922, to Oct 23, 1922.that I last saw him alive on Oct 23, 1922.and that death occurred, on the date stated above, at 6:10 A m.

The CAUSE OF DEATH* was as follows:

Post-partum clampsia(duration) yrs. mos. ds. 1CONTRIBUTORY Pulmonary Oedema (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. W. Gray, M. D.19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Oak Lawn Cem.

DATE OF BURIAL

Oct. 26 1922

20 UNDERTAKER

Lilly and Ziller

ADDRESS

403 S. W. Office

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68612

D 68612

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 S. Bouldin ST., 16 WARD)

2-FULL NAME

Bernhard F. Griebel

(a) RESIDENCE No.

420 S. Bouldin St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced, (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Maria Griebel

6 DATE OF BIRTH (month, day, and year)

April 11 - 1858

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

64

6

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Engineer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

St. Josephs Hosp.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

John Griebel

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Germany

14

Informant
(Address)

Margaret Ulsch Daughter
420 S. Bouldin St.

15

OCT 25 1922
Filed

ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 24 1922

17

I HEREBY CERTIFY, That I attended deceased from
9-29- 1922, to 10-24 1922,

that I last saw him alive on 10-24 1922,

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY
(Secondary)

Mitral Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. K. Schneider M. D.

10-20 1922 (Address) 2439 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Sacred Heart Cem.

20 UNDERTAKER

Lilly End Jailer

DATE OF BURIAL

Oct. 27 1922

ADDRESS

403 S. D. Street

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68613

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph's Hosp* St., *3* Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. *230 S. Spring St.* St.; yrs., *40* mos.ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Black* 5-Single, Married, Widowed, or Divorced, *Married*
(Write the word.)

6-DATE OF BIRTH, *Aug 22* 18*56*
(Month) (Day) (Year)

7-AGE, *66* yrs., *2* mos., *0* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Seaman*
(b) General nature of industry, business, or establishment in which employed (or employer), *Atlantic Iron Co.*

9-BIRTHPLACE, (State or Country), *St Mary's Co Md*

10-NAME OF FATHER, *unknown*

11-BIRTHPLACE OF FATHER, (State or Country), *Unknown*

12-MAIDEN NAME OF MOTHER, *unknown*

13-BIRTHPLACE OF MOTHER, (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. J. J. J. J.*

(Address) *230 S Spring St*

15- *OCT 25 1922* *ROBERT R. KRAUTER*
Filed 192 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 22* 192*2*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis
Was patient at Hospital July 24, 22
(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) *Syphilis*

(Signed) *J. J. J. J. J.* M. D.
(Coroner.)

10-24-1922 (Address) *50 S. Calver St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt-Aurora Ln *Oct-26* 192*2*

20-UNDERTAKER, ADDRESS *1725*

Mrs Robert A Elliot Ashland St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11 WARD)

2-FULL NAME

(a) RESIDENCE NO. 136 E. E. ST. ST. 11 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filing Date

ROBERT R. KRAUTER,

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 23 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 18 1922 to Oct 23 1922

that I last saw him alive on

Oct 23 1922

and that death occurred, on the date stated above, at

8⁴⁵ a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Septicemia, acute

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Not knownDid an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy

(Signed)

19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 68615

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anna E. Trainer

ST. WARD

(a) RESIDENCE NO. Unknown ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 '22

17 I HEREBY CERTIFY, That I attended deceased from
November 14 19 19 to October 23 19 22.
that I last saw her alive on October 23 19 22.
and that death occurred, on the date stated above, at 11:15 PM
The CAUSE OF DEATH* was as follows:

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
83		---	---	

(a) Trade, profession or particular kind of work.....Dressmaking

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pennsylvania

10 NAME OF FATHER	Unknown
-------------------	---------

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER	Unknown
--------------------------	---------

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14	Informant (Address)	Hospital Records, Municipal Hospital.
----	------------------------	--

15 Robert P. Harrison
1000

Registrar

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

~~Burial Permit Clerk~~

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 68616**

CERTIFICATE OF DEATH.

159-001

D 68616

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Gibbons Ave. Hamilton ST. 27 WARD)

2-FULL NAME

Mary Elizabeth Holley.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 10 Gibbons Ave.

ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) Dec 27th, 19217 AGE Years _____ Months 9 Days 27 If LESS than 1 day, _____ hrs. or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)10 NAME OF FATHER Rev Watson E. HollyHolyoke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Mass.12 MAIDEN NAME OF MOTHER Bessie S. Lyddard13 BIRTHPLACE OF MOTHER (city or town) Montgomery Co.(State or country) Md.14 Informant Rev Watson E. Holly(Address) 10 Gibbons Ave.

OCT 25 1922

19

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24th, 192217 I HEREBY CERTIFY, That I attended deceased from Dec 27, 19 21, to Oct 24, 19 22. that I last saw her alive on Oct 23, 19 22 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Spina. Bifida
(Congenital Hydrocephalus)(duration) yrs. 9 mos. 27 ds.

CONTRIBUTORY (Secondary)

Congenital Hydrocephalus(duration) yrs. 9 mos. 27 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) Morris B. Green, M. D.Oct 25, 1922 (Address) Hamilton Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ivy Hill Cemetery, Laurel Md. Oct 26th, 22

20 UNDERTAKER

ADDRESS

William J. O'Keefe1727 N. Liberty St.

D 68617 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68617

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 408 N. Robinson St. 6

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 408 N. Robinson St.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX

4-COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922 to Oct 25, 1922 that I last saw h. alive on Oct 24, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificate.

D 68618 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D 68618

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3543 Cedar av ST.; 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Kate E. Tomlinson

(Residence in Baltimore: No. 3543 Cedar av

St.; 56 yrs., 10 mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Married

6-DATE OF BIRTH,

1865-Dec 10, 1
(Month) (Day) (Year)

7-AGE,

56 yrs., 10 mos. 13 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

Md.

10-NAME OF FATHER,

Henry A. Tomlinson

11-BIRTHPLACE OF FATHER
(State or Country),

Va.

12-MAIDEN NAME OF MOTHER

Harriet Gladfield

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edna Tomlinson

(Address)

3543 Cedar av

15.

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 23, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 11, 1912, to Oct 23, 1922,

that I saw her alive on Oct 22, 1922,

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus & Rectum

(Duration) yrs. 10 mos. 7 ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Oct 23, 1922 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

St. Mary's (Hampden)

Oct 26, 1922

20-UNDERTAKER

ADDRESS

Horace F. Burque

3631 Fall Road

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S MODE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68619

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1234 5th St. ST. 1 WARD 1

(Usual place of abode)			(If nonresident give city or town and State)			
Length of residence in city or town where death occurred	Yrs.	Mos.	ds.	How long in U. S., if of foreign birth?	Yrs.	Mos.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1917

17 I HEREBY CERTIFY, That I attended deceased from
foreman
 _____, 19____, to _____, 19____

that I last saw him alive on Oct 22, 1944.

and that death occurred, on the date stated above, at 5.30 p.m.

The CAUSE OF DEATH* was as follows:

None

9 BIRTHPLACE (city or town) Baltimore
(State or country)

10 NAME OF FATHER John Stairs

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER *Ruth - Friedman*

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

11 Informant Sister Florence
(Address) Boston, Mass.

13 Filed Robt 19 P. EARRICH,

Registrar

Chronic arthritis

11.4.1944 (duration) yrs. mos. da

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. da

18 Where was disease contracted
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy?

What test confirmed diagnosis: *2. H. T. Flower*
(Signed) *H. T. Flower* M. D.

19 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral

20 UNDERTAKER	ADDRESS
H. E. Wiedefeld 914 Burnett	

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68620

CERTIFICATE OF DEATH.

101-001 D 68620

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5000 York Rd.

ST. 27

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Thompson

(Residence in Baltimore: No. 5000 York Road

St.; 73 yrs., 2 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Negro

5-SINGLE,

MARRIED, *Single*
WIDOWED,
OR SEPARATED,
(Write the word.)

6-DATE OF BIRTH,

August 24, 1849
(Month) (Day) (Year)

7-AGE,

73 yrs., 2 mos. — ds.

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *House - 070*(b) General nature of industry, business, or establishment in which employed (or employer), *Servant*9-BIRTHPLACE,
(State or Country),

Kent County

10-NAME OF FATHER,

Perry Thompson

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

Lousia —

13-BIRTHPLACE OF MOTHER
(State or Country),

Kent County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), *Lousia R. Weatherley*(Address), *5000 York Road*

15-

Filed..... Robert, P. Harrison,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 24, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 22, 1922, to Oct 24, 1922,

that I saw her alive on Oct 24, 1922,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (lobar)

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY
(Secondary)

(Duration)..... yrs..... mos..... ds.

(Signed) *E. M. Duncan* M. D.Oct 25, 1922 (Address) *5706 York Road*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. Mary's Church

DATE OF BURIAL,

Oct 26, 1922

20-UNDERTAKER

A. B. Wiedfeld

ADDRESS

914 Thimble Cove Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

61251922

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68621

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68621

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Maple Ave* ST. *27* WARD)

2-FULL NAME *Thomas W. S. Mainley*

(a) RESIDENCE NO. *Maple Ave, Overlea* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *61* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 19-1861*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *61* *4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Lather*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto. City* (State or country) *Md.*

10 NAME OF FATHER *James Mainley*

11 BIRTHPLACE OF FATHER (city or town) *Wm.* (State or country)

12 MAIDEN NAME OF MOTHER *Agnes Ellis*

13 BIRTHPLACE OF MOTHER (city or town) *England* (State or country)

14 Informant *Mrs. M. S. Perry* (Address) *Maple Ave, Overlea*

15 Filed *Dec. 19* *P. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 23* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 22nd*, 19*22*, to *Oct 23rd*, 19*22*.

that I last saw him alive on *Oct 23rd*, 19*22*.

and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH* was as follows:

Locomotor ataxia

(duration) *5* yrs. mos. ds. CONTRIBUTORY (Secondary) *Cerebral Hemorrhage*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Symptoms of Locomotor ataxia*

(Signed) *Edw. W. Benson* M. D.

, 19 (Address) *Overlea Md.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Balto. Cemetery *Oct. 26* 19 *22*

20 UNDERTAKER ADDRESS

Wm. B. Black 927 N. Edwiny

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Syphilis

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68622

CERTIFICATE OF DEATH.

D 68622

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin Square Hospital* ST., *5* WARD)2-FULL NAME *Clara Viola*(a) RESIDENCE NO. *376 Forrest*

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs. mos. ds.

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? *20* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*female white**widow*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *unknown 1862*

7 AGE

Years

Months

Days

8 LESS than 1 day, hrs. or min.

60 yrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Italy*10 NAME OF FATHER *John Brown*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*12 MAIDEN NAME OF MOTHER *John Brown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

14

Informant (Address) *John Viola 376 Forrest St*

15

Filed

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 24 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 22 1922* to *Oct 24 1922*that I last saw her alive on *Oct 23 1922*and that death occurred, on the date stated above, at *8:10 P. m.*

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed *August P. Stefan* M. D.
Oct 25 1922 (Address) *407 N. Egle St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH EXPANDED TYPE. PHYSICIANS should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE: (No.

Lombard & Green

ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ruth L. Stout

(a) RESIDENCE. NO.

3101 Garrison Blvd.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chas. W. Stout

6 DATE OF BIRTH (month, day, and year)

1900

7 AGE

22

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

M. J. Schimmell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Rosalia Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Berlin, Maryland

14

Informant (Address)

Charles Stout

15

1922

Robert E. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-20 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 24, 1922, to Oct. 28, 1922

that I last saw her alive on Oct. 25, 1922

and that death occurred, on the date stated above, at 11:25 a.m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

Diffuse peritonitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 24, 1922

Was there an autopsy? No

What test confirmed diagnosis? Clinico-op. finding

(Signed)

J. H. Brumback, M. D.

Oct. 26, 1922 Address University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto Hebrew

DATE OF BURIAL

Oct 27 1922

20 UNDERTAKER

J. Ahrens & Co

ADDRESS

1611 Madison Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

CT 25 1922

D 68624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68624

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

OCT 26 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Sept 24th, 1922, to Oct 21st, 1922,that I last saw him alive on Oct 21st, 1922,

and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. L. Woodward, M. D.

, 19 (Address) 8 E. Engert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Cemetery Oct 27 1922

UNDERTAKER

Henry Jenkins & Co

ADDRESS

Orchard Hill Collopy

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE
D 68626 38 D 68626

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *University Hospital* St. *12* Ward)

Registered No. C.....

2-FULL NAME *Clara Thornton*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *2005 Oak St.* St.; *9* yrs.; mos.; ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE

Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH,

Aug 24 1894
(Month) (Day) (Year)

7-AGE,

28 yrs. *2* mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

va.

10-NAME OF FATHER,

Robt Thornton

11-BIRTHPLACE OF FATHER,

(State or Country), *va*

12-MAIDEN NAME OF MOTHER,

Susan Dean

13-BIRTHPLACE OF MOTHER,

(State or Country), *va*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Ozle Burrell

(Address)

1701 Belmont

15-

FILE

OCT 26 1922

ROBERT R. KRAUTER

Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 24 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said.

find that said deceased came to *her* death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock following intravenous injection of Mercuric Chloride

(Duration) *45 min.* mos. ds.

CONTRIBUTORY (Secondary)

Went to work

(Duration) yrs. mos. ds.

(Signed) *W. H. Gorman* M. D.

(Coroner.)

10.26.1922 (Address) *417 N. Salisbury*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Luke's Cemetery

Oct 26 1922

20-UNDERTAKER

ADDRESS

W. H. Gorman

1400 Mosher

D 68627.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68627.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Spartan Apts

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

Liberty St. & Hillton 15

WARD)

2-FULL NAME

William Alexander Hudec

(a) RESIDENCE NO.

Liberty St. & Hillton

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 28 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

0 0 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

Nurse

(c) Name of employer

Nurse

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Alex. M. Hudec

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Harrisburg Pa.

12 MAIDEN NAME OF MOTHER

Ruth Kottler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Liberty St. & Hillton 15

15

Filed OCT 26 1922

ROBERT H. KRAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 25 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 28, 1922, to Oct 25, 1922.

that I last saw him alive on Oct 24, 1922.

and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. T. Kemp, M. D.

, 19 (Address) 12 James Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cem

Oct 26 1922

20 UNDERTAKER

ADDRESS

Wm. J. Lickner & Sons

N. Pa.

D 68628

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Shelter for Aged Colored Persons* ST. *17* WARD)2-FULL NAME *Jane Buchanan*(a) RESIDENCE. NO. *Shelter for Aged Colored Persons* ST. *17* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *36* yrs. — mos. — ds.

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female Black Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1936*

7 AGE

86 Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Buchanan*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Don't know*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Don't know*

14

Informant *Matron* (Address) *517 W. Biddle St.*

15

Oct 26 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/25/22*

17

I HEREBY CERTIFY, That I attended deceased from *10/8/22* to *10/25/22* that I last saw him alive on *10/24/22*and that death occurred, on the date stated above, at *3 A. m.*

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

CONTRIBUTORY (Secondary)

Chronic Nephritis (duration) *10* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. B. Harrison*

M. D.

1922 (Address) *1216 D. H. Av.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cemetery Oct 26 1922

20 UNDERTAKER

ADDRESS

Chas. E. Joanch 802 Madison Ave.

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68629

CERTIFICATE OF DEATH.

44 D 68629
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 *Piedmont ave* ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 3411 *Piedmont ave* St.; 13 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married*
(Write the word.)6-DATE OF BIRTH, *Nov. 11th, 1854*
(Month) (Day) (Year)7-AGE, *67* yrs. *11* mos. *13* ds. If LESS than 1 day, — hrs. or — min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Retired Salesman*
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Maryland*10-NAME OF FATHER, *James E. Douglas*11-BIRTHPLACE OF FATHER (State or Country), *Md. —*12-MAIDEN NAME OF MOTHER *Mary Catharina Davis*13-BIRTHPLACE OF MOTHER (State or Country), *Md. —*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Eugene Douglas*(Address) *830 W. North Ave.*

15-226192100 ROBERT R. KRAUTER,

Filed 191— Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 24th, 1912*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 24th, 1912*, to *Oct 24th, 1912*, that I saw him alive on *Oct. 24th, 1912*, and that death occurred, on the date stated above, at *4:7* m. The CAUSE OF DEATH* was as follows:*Carcinoma of Stomach*
(Duration) *2* yrs. *6* mos. — ds.CONTRIBUTORY *None Known*
(Secondary)(Signed) *Eugene Douglas* M. D.
Oct 25, 1912 (Address) *830 W. North Ave.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Frederick Md.* DATE OF BURIAL, *Oct 27, 1912*20-UNDERTAKER *H. M. Rouleau* ADDRESS *2238 12th St. N. W.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SIGNATURE is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bhs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68630

CERTIFICATE OF DEATH.

D 68630

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 211 Roland av ST.; 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harrie Hough

(a) RESIDENCE. No.

211 Roland av ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Nannie H. Hough

6 DATE OF BIRTH (month, day, and year)

Aug 10 1842

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

80

2

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Leather Business

(c) Name of employer

Thos. DeFord Co

9 BIRTHPLACE (city or town) (State or country)

Va

10 NAME OF FATHER

Edw S. Hough

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Susan A. Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant

Mrs Nannie H. Hough

(Address)

211 Roland av

15

OCT 26 1922

ROBERT H. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct-24 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1922, to Oct 24, 1922, that I last saw him alive on Oct. 24, 1922, and that death occurred, on the date stated above, at 10.20, P. m. The CAUSE OF DEATH* was as follows:

Atherosclerosis

(duration) 4 yrs. 8 mos. 8 ds.

CONTRIBUTORY (Secondary)

Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clarke M. D.

Oct 25, 1922 (Address) Latrobe Apt. Char Road 8

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Olivet Cem

Oct 27 1922

20 UNDERTAKER

Henry W. Jenkins & Sons

ADDRESS

McCallister & Richard

D 68631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31-D 68631

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3421 Eastern Ave. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town, State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town, State or country)

14

Informant (Address)

15

OCT 26 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY that I attended deceased from July 3, 1922 to Oct 24, 1922 that I last saw him alive on Oct 23, 1922

and that death occurred, on the date stated above, at 12 noon

THE CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. L. Reckard, M. D.

Address) 2100 Adell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D 68632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68632

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos.

ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 12, 1922, to Oct. 24, 1922, that I last saw him alive on Oct 24, 1922, and that death occurred, on the date stated above, at 30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) (duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo D. Dwyers, M. D., 19 (Address) 2818 E. Duncannon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68633

D 68633

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1429 W. 36

ST. 13 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Enoch E. Penn

(Residence in Baltimore: No. 1429 W. 36 & 24

St. 35 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male. 4-COLOR OR RACE, White. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Feb 4, 1849 (Month) (Day) (Year)

7-AGE, 73 yrs., 9 mos., 20 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Patient Clerk. (b) General nature of industry, business, or establishment in which employed (or employer), Pa. Ry.

9-BIRTHPLACE, (State or Country), Annapolis Co. Md

10-NAME OF FATHER, Joshua Penn

11-BIRTHPLACE OF FATHER (State or Country), Annapolis Co. Md

12-MAIDEN NAME OF MOTHER, Ask not known

13-BIRTHPLACE OF MOTHER (State or Country), Ask not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

OCT 26 1922

191

ROBERT H. MAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

October 24th, 1912 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 1st, 1912, to Oct 24th, 1912, that I saw him alive on Oct 24, 1912, and that death occurred, on the date stated above, at 11.10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Duration) 1 yrs., — mos., — ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis, Stenosis of Cor. (Duration) 15 yrs., — mos., — ds.

(Signed) J. P. P. P. P. M. D. Oct 24, 1912 (Address) 1429 W. 36 & 24

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, — yrs., — mos., — ds. In the State, — yrs., — mos., — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

St Mary's N Oct 27, 1912

20-UNDERTAKER ADDRESS

A. S. Marshall 3538 J. Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68634

CERTIFICATE OF DEATH.

D 68634

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1816 Bolton ST. 14 WARD)

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Lora Griffith(Residence in Baltimore: No. 1816 Bolton St St. 65 yrs., 4 mos., 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. 74-COLOR OR RACE, wh5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)6-DATE OF BIRTH, Jan 20 1887

(Month)

(Day)

(Year)

7-AGE, 65 4 11

yrs. mos. ds.

If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular
kind of work.
(b) General nature of industry, business, or establishment in which
employed (or employer).9-BIRTHPLACE,
(State or Country), Baltimore10-NAME OF
FATHER, James J. Griffith11-BIRTHPLACE
OF FATHER
(State or Country), Baltimore12-MAIDEN NAME
OF MOTHER Maria Hogan13-BIRTHPLACE
OF MOTHER
(State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Carrie Griffith(Address) 1816 Bolton St

15-

OCT 26 1922

ROBERT R. KRAUTER,

Filed

191

Burial Permit Clerk,
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 25, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from
Sept 19 1922, to Oct 25 1922that I saw her alive on Oct 25 1922and that death occurred, on the date stated above, at p m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Myocarditis and aortic Regurg.

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....Pulmonary & Renal
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed).....Charles F. Blakely M. D.Oct 26, 1922 (Address).....20 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted,
if not at place of death?Former or
usual residence19-PLACE OF BURIAL OR REMOVAL, Howell ParkDATE OF BURIAL, Oct 28, 1922

20-UNDERTAKER

George J. Smith

ADDRESS

1332 Hollins St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S SHOULD STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS AN IMPORTANT RECORD—PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—4-10-21 M&T 1500 lka.

D 68635

Doyle
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68635

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Bolton ST., 14 WARD)

2-FULL NAME Daniel Henry Doyle

(a) RESIDENCE NO. 1612 Bolton ST., WARD

(Usual place of abode)
Length of residence in city or town where death occurred 66 yrs. 3 mos. 6 ds. (If non-resident give city or town and State)

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed,
or Divorced, (write the word) Married

5a If married, widowed, or divorced
HUSBAND of Catherine A. Flynn
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 18, 1856

7 AGE Years 66 Months 3 Days 6 If LESS than
1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Retired - Retail Carpet

(b) General nature of industry,
business, or establishment in
which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER William H. Doyle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant William H. Doyle
(Address) 1612 Bolton St.

15 Filed OCT 26 1922 ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 24 1922

17 I HEREBY CERTIFY, That I attended deceased from
July 1, 1922, to Oct 24, 1922.
That I last saw him alive on Oct 23, 1922.

and that death occurred, on the date stated above, at 5:05 P. m.

The CAUSE OF DEATH* was as follows:

Art. Schrosis & Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Central Lymphadenitis

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Refractive Action - Chy -

(Signed) E. J. O'Keefe, M. D.

6215, 1912 (Address) 5 E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Cathedral Cemetery

DATE OF BURIAL

10/27, 1922

20 UNDERTAKER

Henry W. Hears & Son 805

ADDRESS

W. Calvert

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68637

CERTIFICATE OF DEATH.

D 68637
1. PLACE OF DEATHCITY OF BALTIMORE: (No. Municipal Hospital ST. 14 WARD)2. FULL NAME Calvin Derrick
1526 McCullough St(a) RESIDENCE NO. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced
HUSBAND of Unknown
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18847 AGE Years Months Days If LESS than 1 day, hrs. or min.
38 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland10 NAME OF FATHER Joshua Derrick11 BIRTHPLACE OF FATHER (city or town) Balto.,
(State or country) Md.12 MAIDEN NAME OF MOTHER Jennie Spriggs 10/25/22 Address Municipal Hospital.13 BIRTHPLACE OF MOTHER (city or town) Balto.,
(State or country) Md.14 Informant Municipal Hospital Records.
(Address)15 OCT 26 1922 ROBERT R. KRAUTER,
Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 19 2217 I HEREBY CERTIFY, That I attended deceased from
October 19, 19 22, to October 25, 19 22,
that I last saw him alive on October 24, 19 22,
and that death occurred, on the date stated above, at 2:00 A.M.
The CAUSE OF DEATH* was as follows:Tuberculosis(duration) 2 yrs. mos. ds.CONTRIBUTORY Broncho pneumonia
(Secondary) (duration) 2 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date of Was there an autopsy? YesWhat test confirmed diagnosis? CSE etc
(Signed) Clyde A. Muel, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL DATE OF BURIAL Oct 26 19 22UNDERTAKER ADDRESS N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68638

CERTIFICATE OF DEATH.

D 68638

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *18* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *Chilman Home* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-Status,
Married,
Widowed,
or Divorced.
(Write the word.)

6-DATE OF BIRTH.

(Month) (Day) (Year)

7-AGE.

..... yrs. *2* mos. ds.

If LESS than 1 day,

..... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE.
(State or Country).

Bald Md.

PARENTS.

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER.
(State or Country).

12-MAIDEN NAME OF MOTHER,

Hester Wilson

13-BIRTHPLACE OF MOTHER.
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

OCT 26 1922 ROBERT R. KRAUTER,

192

Burial Permit Clerk Registrar.

19612

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct

23

192 *2*

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, au-

topsy or inquiry.) And that said deceased came to..... death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia.

(P. M. Hopkins)

..... (Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) *J. H. Walter* M. D.

as 23 1922 (Address) *518 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

HOPKINS HOSPITAL

19.....

20-UNDERTAKER,

ADDRESS

Commissioner Health,

OCT 25 1922

W. F. WOODALL

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH **D 68639**CITY OF BALTIMORE: (No. Municipal Hospital. ST. 76 WARD)2-FULL NAME Albert Conover(a) RESIDENCE No. Unknown

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST. 76 WARD

WARD

(If non-resident give city or town and State)

REGISTERED NO. **D 68639**
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Unknown5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18787 AGE Years 44 Months -- Days -- If LESS than 1 day, -- hrs. or -- min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Connecticut
(State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)14 Informant Hospital Records, UNIVERSITY OF MARYLAND
(Address) Municipal Hospital.15 Oct 26 1922 ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23 19 2217 I HEREBY CERTIFY, That I attended deceased from July 3, 19 22, to October 23, 19 22.that I last saw him alive on October 23, 19 22.and that death occurred, on the date stated above, at 11:40 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
(duration) 2 yrs. mos. ds.CONTRIBUTORY Obesity; Hypertension
(Secondary) (duration) 5 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Clayton R. Neil, M. D.10/24/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MUNALITY UNIVERSITY OF MARYLAND

DATE OF BURIAL

OCT 26 1922

20 UNDERTAKER

ADDRESS

Commissioner Health,

B. B. WHITE PLAIN, WITH ONE-DRIVE THE CITY OF BALTIMORE. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR- TION is very important. See instructions on back of certificates.

19616

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name of organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No other history.

HEALTH DEPARTMENT—CITY OF BALTIMORE **D 68640****D 68640**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Ind. Gen. Hosp* ST.: *19* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs Mary Muller*(a) RESIDENCE. No. *1609 E. Green Ave.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *18* yrs. mos. ds. How long in U. S., if of foreign birth? *18* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *May - 1863*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *59*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *Herman Petzold*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *May E. Petzold*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*14 Informant *W. H. Peadar* (Address) *300 E. Main St.*15 Filed *OCT 26 1922* ROBERT H. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 25 1922*17 I HEREBY CERTIFY, That I attended deceased from *10/21/22* to *10/25/22*that I last saw her alive on *10/25/22*, 19and that death occurred, on the date stated above, at *8:30* a. m.

The CAUSE OF DEATH* was as follows:

Peritonitis
Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Septicemia*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *10/21/22*Was there an autopsy? *none*What test confirmed diagnosis? *Clinical symptoms*(Signed) *J. A. Thompson*, M. D., 19 (Address) *Ind. Gen. Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Petersburg Va.**10/26/22*20 UNDERTAKER ADDRESS *1442**Robt J Turner Inc 91 Broadway*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68641

CERTIFICATE OF DEATH.

90 D 68641
REGISTERED NO. C

CITY OF BALTIMORE, (No. 2412 E. Biddle St.)

2-FULL NAME

Albertina Henrietta Ulrich

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2412 E. Biddle St.)

35 yrs., 8 mos., 16 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F.

4-COLOR OR RACE,

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

widowed

6-DATE OF BIRTH.

Feb. 10, 1837

(Month)

(Day)

(Year)

7-AGE

85 yrs., 8 mos., 15 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

at home

9-BIRTHPLACE, (State or Country),

Germany

10-NAME OF FATHER,

unknown

11-BIRTHPLACE OF FATHER (State or Country),

Germany

12-MAIDEN NAME OF MOTHER

Unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Edw. O. Deeger

(Address)

2412 E. Biddle

15-

OCT 26 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct

25,

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 6, 1922, to Oct 25, 1922,

that I saw her alive on Oct 24, 1922,

and that death occurred, on the date stated above, at 12 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac & Respiratory
Paralysis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. E. Deeger M. D.

Oct 25, 1922 (Address) 1301 N. E. Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Baltimore City

Oct 27, 1922

20-UNDERTAKER

ADDRESS

Winlock, 5028 North ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH CARE AND ACCURACY. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.
D 68642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68642

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Robt Garrett Hosp for Children*
CITY OF BALTIMORE: (No. *27 N. Carey* ST., *8* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James Watts*
(a) RESIDENCE No. *3415 Harford Ave* ST., _____ WARD _____
(Usual place of abode)

Length of residence in city or town where death occurred *life* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *April 24 1922*

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or min. *5 1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Child*
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town, State or country) *Balto Md*

10 NAME OF FATHER *George F. Watts*

11 BIRTHPLACE OF FATHER (city or town, State or country) *Balto*

12 MAIDEN NAME OF MOTHER *Mary Sagan*

13 BIRTHPLACE OF MOTHER (city or town, State or country) *Md*

14 Informant *Geo. F. Watts*
(Address) *3415 Harford Ave*

15 Filed *Oct 26 1922* ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 25 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 7*, 19*22*, to *October 25*, 19*22*, that I last saw him alive on *October 25*, 19*22*, and that death occurred, on the date stated above, at *7:15 P. m.*
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia following Pertussis

(duration) _____ yrs. *9* mos. *9* ds.
CONTRIBUTORY *Gastro Intestinal Indigestion & Pericarditis Media*
(Secondary) (duration) _____ yrs. *2* mos. _____ ds.

18 Where was disease contracted if not at place of death? *unknown*

Did an operation precede death? *no* Date of _____

Was there an autopsy? *no*

What test confirmed diagnosis? *Physical Exam*
(Signed) *J. G. Clark*, M. D.

Oct 26, 1922 (Address) *27 N. Carey St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *Long Green Md* DATE OF BURIAL *Oct 27 1922*

20 UNDER TAKER *Wm Croft* ADDRESS *502 E North*

13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100-101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000

D 68644

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 68644

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Collington Ave ST. WARD)

2. FULL NAME

Agnes Cieslinska

(a) RESIDENCE NO.

507 S. Collington Ave

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 3 yrs. mos. ds.

How long in U. S., if of foreign birth? 5 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Ignatius Cieslinski

6 DATE OF BIRTH (month, day, and year)

Jan 6 - 1874

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

9

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Martin Smiglewski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Antonina Hojnacka

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Lilla Cieslinska # 507 S. Collington Ave

15

Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1922, to Oct. 25, 1922,

that I last saw her alive on Sept. 15, 1922,

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

Cardiac Failure

18 Where was disease contracted

At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Chas. O. Neer, M. D.

(Address) 408 S. Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVA

St. Stanislaus

DATE OF BURIAL

Oct 28, 1922

20 UNDERTAKER

M. J. Sudowski

ADDRESS

705 S. Am St

D 68645

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68645

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *11. White Ave. near* ST. *Harford Road* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Catherine Hofstetter*(a) RESIDENCE NO. *11. White Ave. near* ST. *Harford Road* WARD *Hamilton*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *70* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Feb. 11th 1844*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 24 1922*

17

I HEREBY CERTIFY, That I attended deceased from
Oct 16, 1922, to *Oct 24*, 1922.that I last saw *her* alive on *Oct 24*, 1922.and that death occurred, on the date stated above, at *745* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum(duration) *2* yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(duration) — yrs. *6* mos. — ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Morris B. Green*, M. D.*Oct 25 1922* (Address) *Hamilton Baltimore Md*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

26 1922

Burial Permit Given

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D 68646

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68646

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2125 E Preston ST., 8 WARD)

2-FULL NAME

Anna E. Baer

(a) RESIDENCE NO.

2125 E Preston

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds.

(If non-resident give city or town and State)
How long in U. S., if of foreign birth? 70 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of

Henry Baer

6 DATE OF BIRTH (month, day, and year)

July 28th 1834

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

88

2

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER (Unknown) Schott

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Catherine Baer 2125 E Preston

15

Robert P. Harris

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25th 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 1st 1922, to Oct 25th 1922,

that I last saw her alive on Oct 24th 1922,

and that death occurred, on the date stated above, at 1.50 a m.

The CAUSE OF DEATH* was as follows:

Infirmitas of age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Enoch C. Rehner M. D.

Oct 25 1922 (Address) 928 No. Caroline Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Trinity Lutheran Cemetery

DATE OF BURIAL

Oct 28th 1922

20 UNDERTAKER

George Schilling & Sons

ADDRESS

1126 E. Monmouth

D 68647

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68647

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11 WARD)2-FULL NAME Howard Webb(a) RESIDENCE No. 1242 E. Madison St. ST. _____ WARD _____
(Usual place of abode)Length of residence in city or town where death occurred 18 yrs. 6 mos. 2 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) April 23-19047 AGE Years 18 Months 6 Days 2 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER James Webb11 BIRTHPLACE OF FATHER (city or town) W. Virginia (State or country) _____12 MAIDEN NAME OF MOTHER Rebecca Montgomery13 BIRTHPLACE OF MOTHER (city or town) Monaca Co. Pa (State or country) _____14 Informant JOHNS HOPKINS HOSPITAL (Address) Records15 Filed Robert P. Harrison, 19 _____

Registrar

Serial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 192217 I HEREBY CERTIFY, That I attended deceased from Oct 2-1922 to Oct 25 1922 that I last saw him alive on Oct 25 1922and that death occurred, on the date stated above, at 135 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
uremia(duration) 1 yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted? _____ if not at place of death? _____

Did an operation precede death? No Date of _____Was there an autopsy? YesWhat test confirmed diagnosis? Autopsy (Signed) Chas. R. Bugg M. D.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Baltimore CemeteryOct 30 1922

20 UNDERTAKER

ADDRESS

George Schilling & Sons 1126 E. Monument St.

N. B.—WRITE PLAINLY. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68648

CERTIFICATE OF DEATH.

D 68648

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Jrs. Hosp.* ST. *8* WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of*None*

6 DATE OF BIRTH (month, day, and year)

Oct 22 1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*0**0**3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore*

10 NAME OF FATHER

*Arthur Richmond*11 BIRTHPLACE OF FATHER (city or town)
(State or country)*Baltimore*

12 MAIDEN NAME OF MOTHER

*Robert Mitchell*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)*Baltimore*

14

Informant
(Address)*Clara J. Smith*
4706 Harford Ave

15

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 28 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct 24, 19*22*, to *Oct 28*, 19*22*that I last saw him alive on *Oct 25*, 19*22*and that death occurred, on the date stated above, at *5:15 P. M.*

The CAUSE OF DEATH* was as follows:

Coronary

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)*Prostate Cancer*

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clara J. Smith, M. D.

, 19

(Address)

4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Greenmount Cemetery

20 UNDERTAKER

George Schilling Sons

DATE OF BURIAL

Oct 27 1922

ADDRESS

1126 E. Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

GT 261922

D 68649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68649

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto Gen Hosp* ST., *6* WARD)2-FULL NAME *Mrs. Hilda Schiller*(a) RESIDENCE NO. *2007 Orleans St* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *20* yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Frank Schiller*6 DATE OF BIRTH (month, day, and year) *Mar 14-1870*7 AGE Years *52* Months *7* Days *7* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Pa*10 NAME OF FATHER *Don't know*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Don't know*12 MAIDEN NAME OF MOTHER *Don't know*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Don't know*14 Informant *Frank Schiller* (Address) *2007 Orleans St*15 Filed *1927* *Robert P. Harrison* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 26 1927*

17

I HEREBY CERTIFY, That I attended deceased from *October 18*, 19*27*, to *October 26*, 19*27*.that I last saw him alive on *October 26*, 19*27*.and that death occurred, on the date stated above, at *5 30* p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Arrhythmia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *No*Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John A. Cannon*, M. D.19 (Address) *South Balto Gen Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Baltimore Cemetery

DATE OF BURIAL

Oct 28 1927

20 UNDERTAKER

John Reelick

ADDRESS

2008 Orleans

B.—WRITE PLAINLY, WITH CAREFULNESS. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68650

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 602 Dukeland ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

May K. Brown

(a) RESIDENCE. NO.

602 Dukeland ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~Single, Married, Widowed, or Divorced~~ (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 23 18677 AGE Years 54 Months 10 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER Wm O Cook11 BIRTHPLACE OF FATHER (city or town) (State or country) Maine12 MAIDEN NAME OF MOTHER Annie E. Martin13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md14 Informant Annie Brown (Address) 602 Dukeland Av15 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) OCT 26 1922

17

I HEREBY CERTIFY, That I attended deceased from April, 1921, to October 25, 1922, that I last saw him alive on October 25, 1922, and that death occurred, on the date stated above, at 6:05 A m. The CAUSE OF DEATH* was as follows:Myocardial degeneration(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chr. Parachymatous Hepatitis(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) J. T. Hennessy, M. D.19 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St O LiveOCT 28 1922

20 UNDERTAKER

ADDRESS

Geo W Little

2700 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

dl. 68651 HEALTH DEPARTMENT—CITY OF BALTIMORE dl. 68651
100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Cherry St., Curtis Bay 25 ST., WARD)

2-FULL NAME

(a) RESIDENCE No. 12 Cherry St.
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 10 mos.

ST., WARD
(If non-resident give city or town and State)
ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 Single, Married, Widowed,
or Divorced, (write the word) married5a If married, widowed, or divorced
HUSBAND of Josephine Tomiska
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1834

7 AGE Years 88 Months ? Days ? If LESS than
1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Farmer(b) General nature of industry,
business, or establishment in
which employed (or employer) Has not worked
for years.

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Catherine Robert

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria14 Informant Annie Rozar
(Address) 12 Cherry St., Curtis Bay

15 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 1922

17 I HEREBY CERTIFY, That I attended deceased from
Oct. 25th, 1922, to Oct. 26, 1922.

that I last saw him alive on Oct. 26, 1922.

and that death occurred, on the date stated above, at 9:10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. B. Davis, M. D.

1922 (Address) 211 Church St., Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

20 UNDERTAKER

ADDRESS

PHYSICIANS should state
EXACTLY. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

CT261922

D 68652 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68652

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1034 Edmondson Ave. Ward 16)

Registered No. C.....

2-FULL NAME

Louis F. Dobner

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1034 Edmondson Ave. St.; 70 yrs., 11 mos., 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced, married
(Write the word.)

6-DATE OF BIRTH, Nov. 5, 1851
(Month) (Day) (Year)

7-AGE, 70 yrs., 11 mos., 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, U.S.S. Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, John Dobner

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mrs. L. F. Dobner

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. F. Dobner

(Address) 1034 Edmondson Ave.

15- Robert P. Harrison,

Filed 1922 Registrar.

1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct. 24, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) 10 min. yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Signed) J. E. Hennessey, M. D. (Coroner.)

(Address) 2872 Cambridge St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, 70 yrs., 11 mos., 14 ds. In the State, 70 yrs., 11 mos., 14 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Louisa DATE OF BURIAL, October 26, 1922

20-UNDERTAKER, Geo. W. Little ADDRESS Edmondson Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68653 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 ST., 12 WARD)

2-FULL NAME Julia Jones Hayes

(a) RESIDENCE NO. 18 Cor Charles & 32

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. \ mos. \ ds.

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

None

6 DATE OF BIRTH (month, day, and year) Nov 1 1852

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

64

11

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Potsdam

10 NAME OF FATHER

Wm C Hayes

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Juliana Gordon

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

PARENTS

14

Informant (Address)

Wm C Hayes 327 Charles

15

Filed

Robert P. Harrison, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 25 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 29 1920 to Oct 25 1922

that I last saw him alive on

Oct 20 1922

and that death occurred, on the date stated above, at 9 00 m.

The CAUSE OF DEATH* was as follows:

acute Bronchitis -
Pneumo pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 12
chronic interstitial nephritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

examination - mal
fract. etc - mal
fract. etc - mal

(Signed)

19 (Address)

1025 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Wm C Hayes 327 Charles

Wm C Hayes 327 Charles

PHYSICIANS should state EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OCT 28 1922

Burial Permit Class 2.

D 68654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68654

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 N. Eden ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Baby Berger

(a) RESIDENCE NO.

921 N. Eden

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 25 = 1922

7 AGE

Years

Months

Days

If LESS than 1 day, 15 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Thomas J. Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Rosina Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mrs. Berger 921 N. Eden St.

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-26-22

17

I HEREBY CERTIFY, That I attended deceased from Oct 25th 1922, to Oct 26th 1922, that I last saw him alive on Oct 26th 1922.

and that death occurred, on the date stated above, at 7:00 m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary
since birth
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Baltimore Cemetery Oct 27 1922
Henry Lutz 1203 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCASION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

26 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68655

CERTIFICATE OF DEATH.

D 68655

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1310 Rutter*

ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Benjamin LaRue

(a) RESIDENCE NO.

1310 Rutter

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *45* yrs. *9* mos. *11* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

9

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Salver

(b) General nature of industry, business, or establishment in which employed (or employer)

Had Carriage

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Port Deposit Md

10 NAME OF FATHER

Same

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Port Deposit

12 MAIDEN NAME OF MOTHER

Hester Melson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Port Deposit Md

14

Informant (Address)

15

Filed *27* 1922

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 22* 1922

17

I HEREBY CERTIFY, That I attended deceased from

, 19, to, 19,

that I last saw him alive on, 19,

and that death occurred, on the date stated above, at *1 P* m.

The CAUSE OF DEATH* was as follows:

Exhaustion

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

3 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Wm L Rittall

M. D.

, 19

(Address)

1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

Laurel Cemetery

10/27 1922

20 UNDERTAKER

ADDRESS

Mrs A C Elliott 1728 Ashland

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Esther 406 N. Charles St. or on way to mercy hospital* St. *15* Ward *90*)

Registered No. **D 68656**

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James L. Clark*

(Residence in Baltimore: No. *1327* *Quasman St* St.; yrs. *30* mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE *Col*

5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH

(Month)

(Day)

(Year)

7-AGE

41 yrs.mos.ds.

If LESS than 1 day,

....hrs. ormin.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work. *Yabney*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country). *Va.*

10-NAME OF FATHER. *W. R. Brown*

11-BIRTHPLACE OF FATHER. *Not known*
(State or Country).

12-MAIDEN NAME OF MOTHER. *Not known*

13-BIRTHPLACE OF MOTHER. *Not known*
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Doe*

(Address)

15.

OCT 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Oct 24*

(Month)

(Day)

192 *22*
(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv. dis. heart

CONTRIBUTORY (Secondary) *Heart failure*

(Duration)yrs.mos.ds.

(Signed) *W. J. Miller*

(Coroner)

192 *2* (Address) *1037 E. Evers*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions, Transients, or Recent Residents).

At place of death *For 2 yrs.* In the *State* yrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

20-UNDERTAKER.

ADDRESS *1303*

Gas. H. H. Brown

Quasman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68657

CERTIFICATE OF DEATH.

D 68657

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 420 W. Hematta ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Wayman George

(a) RESIDENCE NO. 420 W. Hematta ST., 22 WARD
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, W. dowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 9th 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
One Five Sixteen

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER Clifton George

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Marie Baker

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Marie George
(Address) 420 W. Hematta St.

15 Filed OCT 27 1922 ROBERT R. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24th, 1922, to Oct. 25th, 1922, that I last saw him alive on Oct. 25th, 1922, and that death occurred, on the date stated above, at 10 P. m.
The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY Pneumo-Pneumonia
(Secondary)

(duration) ? yrs. 3 mos. 3 ds.

18 Where was disease contracted ✓
if not at place of death?

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. H. Carroll, M. D.

1426 (Address) 140 W. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Lynchburg, N. C.

10/27 1922

20 UNDERTAKER

ADDRESS

Mrs. Carrie Hooper

406 W. Conway St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Galisi
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68658

CERTIFICATE OF DEATH.

74-001 D 68658

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Hollins St. 18 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1207 Hollins St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Polezols Galce

6 DATE OF BIRTH (month, day, and year) Unknown 1854

7 AGE 63 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Product

(b) General nature of industry, business, or establishment in which employed (or employer) dealer

(c. Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Alvarado Galce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant M. Travis Galce (Address) 1039 Hollins St.

15 Filed 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1922, to Oct 26, 1922, that I last saw him alive on 10/25/22, 19, and that death occurred, on the date stated above, at 7 a. m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert H. Levy, M. D. (Address) 1735 E. Wisconsin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL New Catholic Cem DATE OF BURIAL Oct 30 1922

20 UNDERTAKER J. J. Cowan ADDRESS 901 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68659

CERTIFICATE OF DEATH.

D 68659

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 East 22nd St. ST. 9 WARD)

2-FULL NAME Caroline E. Baumgartner

(a) RESIDENCE NO. 707 East 22nd ST. 9 WARD

(Usual place of abode) Length of residence in city or town where death occurred 66 yrs. 3 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Baumgartner

6 DATE OF BIRTH (month, day, and year) July - 2 - 1856

7 AGE Years 66 Months 3 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER John H. Drist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Fishbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Andrew Baumgartner (Address) 707 E 22 St

15 Filed OCT 27 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 19 22

17 I HEREBY CERTIFY, That I attended deceased from February 25, 19 22, to Oct. 26, 19 22, that I last saw her alive on Oct. 25, 19 22, and that death occurred, on the date stated above, at 3:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) 3 yrs. 8 mos. 8 ds.

CONTRIBUTORY General Carcinomatosis (Secondary)

(duration) 3 yrs. 8 mos. 8 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of (?)

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G. E. Burton, M. D.

10/27, 19 22 (Address) 301 E. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Greenmount Cem

20 UNDERTAKER E. Schloman & Son

DATE OF BURIAL Oct 26 19 22

ADDRESS 1339

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68660

CERTIFICATE OF DEATH. 107-003

D 68660

1-PLACE OF DEATH *St. Agnes Hosp.*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. *20* ST., *20* WARD)2-FULL NAME *Jacob Bach*(a) RESIDENCE NO. *3111 Strickland*

(Usual place of abode)

ST., *20* WARD

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *36* yrs. — mos. — ds. How long in U. S., if of foreign birth? *36* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Wh

5 Single, Married, Widowed, or Divorced, (write the word)

*Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Thecla Bach*6 DATE OF BIRTH (month, day, and year) *May 1-1865*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*57**5**23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer*(b) General nature of industry, business, or establishment in which employed (or employer) *Cemetery*(c) Name of employer *New Cathedral Cemetery*9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *Sebastian Bach*

11 BIRTHPLACE OF FATHER (city or town)

(State or country) *Germany*12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) *Germany*

14

Informant (Address) *Mrs. Thecla Bach (wife)*

15

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10-24* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

4-27, 19 *22*, to *10-24*, 19 *22*,that I last saw him alive on *10-24*, 19 *22*and that death occurred, on the date stated above, at *11:30 p* m.

The CAUSE OF DEATH* was as follows:

multiple pulmonary embolism(duration) yrs. *7* mos. ds.CONTRIBUTORY (Secondary) *Pulmonary Embolism*

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? *Home*Did an operation precede death? *5-10-22* Date of *operation*Was there an autopsy? *No*What test confirmed diagnosis? *operation - X-Ray*(Signed) *W.C. Sullivan*, M. D., 19 (Address) *St. Agnes Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral Cemetery**Oct. 28 1922*

20 UNDERTAKER

ADDRESS

*Elmer W. Conklin,**924 E. Eager St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68661 HEALTH DEPARTMENT—CITY OF BALTIMORE **D 68661**

CERTIFICATE OF DEATH

1 PLACE OF DEATH

CITY OF BALTIMORE (No. *1208 Hull St.*)

2 FULL NAME *Norman Brigrum*

(Residence in Baltimore: No. *1208 Hull St.*)

REGISTERED NO. *268661*

ST. *24* WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Str.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 SINGLE, MARRIED, WIDOWED OR DIVORCED *Single*

6 DATE OF BIRTH *Oct. 26, 1922*

7 AGE *14* yrs. mos. ds. or min.?

8 OCCUPATION *Infant*

9 BIRTHPLACE (State or country) *Baltimore Md.*

PARENTS

10 NAME OF FATHER *Milton Brigrum*

11 BIRTHPLACE OF FATHER (State or country) *Baltimore Md.*

12 MAIDEN NAME OF MOTHER *Bessie Reine*

13 BIRTHPLACE OF MOTHER (State or country) *Baltimore Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Milton Brigrum*

(Address) *1208 Hull St.*

15 *OCT 27 1922* *ROBERT R. KRAUTER,*

Filed *1922* *Bureau of Health* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct. 26, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct. 26, 1922* to *Oct. 26, 1922*

that I saw *him* alive on *Oct. 26, 1922*

and that death occurred, on the date stated above, at *3 P.* m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) *14* hrs.

Contributory (SECONDARY)

(Signed) *Thos. H. Shors* M. D.

10/26/22 (Address) *2878 Hayford Rd.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death *14* yrs. *14* mos. *14* ds. State *14* yrs. *14* mos. *14* ds.

Where was disease contracted?

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Cedar Hill*

DATE OF BURIAL *10/27/1922*

20 UNDERTAKER *Wm. J. L. Lenz*

ADDRESS *1318 Light St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Church Home*

CITY OF BALTIMORE: (No. *Madison* ST., *1* WARD)

2-FULL NAME *Ms. Ellen Carpenter*

(a) RESIDENCE NO. *3113 E. Baltimore* ST., WARD

(Usual place of abode)
Length of residence in city or town where death occurred *7* yrs. — mos. — ds. How long in U. S., if of foreign birth? *7* yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Thos. J. Carpenter*

6 DATE OF BIRTH (month, day, and year) *Feb. 1, 1870*

7 AGE Years *52* Months *8* Days *25* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer) *at Home*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *England*

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) *England*

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *England*

14 Informant: *Thos. J. Carpenter* (Address) *3113 E. Baltimore Street*

15 Filed *OCT 27 1922* Registrar *GLS*

REGISTERED NO. *86862*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 26, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 14, 1922*, to *Oct 26, 1922*, that I last saw him alive on *Oct 26, 1922*, and that death occurred, on the date stated above, at *11:40 am*.

The CAUSE OF DEATH* was as follows:
metastatic carcinoma
lungs
Metastatic Carcinoma Liver

CONTRIBUTORY (Secondary) *Carcinoma Breast*
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *no*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical Micro*

(Signed) *Richard S. Coburn* M. D.

, 19 (Address) *Church Home*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *Oak Lawn Cem.* DATE OF BURIAL *Oct 27 1922*

20 UNDERTAKER *Philip Herwig* ADDRESS *2116 Calumet*

68663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 268663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Wellington ST. 15 WARD)

2-FULL NAME

Mrs. Margaret A. Cox

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 2911 Windsor Ave. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) widow

5a If married, widowed or divorced, name of husband or wife of Samuel F. Cox.

6 DATE OF BIRTH (month, day, and year) June 10/1840

7 AGE Years 82. Months 4 Days 14. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer) Retired (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER David Ports

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Priscilla Jent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Priscilla Swatzbaugh (Address) 2911 Windsor Ave.

15 Filed OCT 27 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct-25-1922

17 I HEREBY CERTIFY, That I attended deceased from Oct-10-1922, to Oct-25-1922, that I last saw her alive on Oct-25-1922, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows: Hemiplegia Right side.

CONTRIBUTORY (Secondary) Arteriosclerosis Chronic Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Was there an autopsy? No

What test confirmed diagnosis? (Signed) Harry C. Allen, M. D. (Address) 3640 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Chenoweth & Son 10/28/1922

Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCURRENCE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (NO. 3556 Tool St. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eloa Barnes(a) RESIDENCE. NO. 3556 Tool St. ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE 4 COLOR OR RACE WHITE 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 25/18977 AGE Years 25 Months 8 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.10 NAME OF FATHER Amos Barnes11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.12 MAIDEN NAME OF MOTHER Edw F Gore13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.14 Informant Amos Barnes(Address) 3556 Tool St15 Filed OCT 27 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 192217 I HEREBY CERTIFY, That I attended deceased from Oct 27th, 1922, to Oct 25th, 1922.that I last saw her alive on Oct 25th, 1922.and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar PneumoniaCONTRIBUTORY (duration) yrs. mos. ds. Persistent Constant Epileptic Seizures (duration) yrs. mos. ds. 4

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. Liliak, M. D.Oct 25 1922 address 1527 Union Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Mary's Hospital 10/28 1922

20 UNDERTAKER ADDRESS

Cummins & Son 311 E. Pratt St.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68665 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 1179 68665

1-PLACE OF DEATH Bay View St. 76 Ward (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Foster Cockeyville, Md. (Residence in Baltimore: No. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Male 4-COLOR OR RACE Black 5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH Unknown 1889 (Month) (Day) (Year)

7-AGE 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

10-NAME OF FATHER Basil Foster

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-NAME OF MOTHER Elizabeth A. Foster

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Edna Foster (Address) Cockeyville, Md

15- Filed OCT 27 1922 19 Registrars

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Oct 25, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held a Inquest thereon and from the evidence obtained a topsy or inquiry.) and that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows: Septic Poisoning

CONTRIBUTORY (Secondary) Burned foot

(Signed) J. H. Horton, M. D. Address 201 N. E. St. Baltimore, Md

*State the Disease Causing Death, or Causes, state (1) Means of death, whether suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?

19- PLACE OF BURIAL OR REMOVAL, Date of Burial, Undertaker, Address

HEALTH DEPARTMENT—CITY OF BALTIMORE
D 68666

CERTIFICATE OF DEATH

D 68666

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *94 Copley Ave* ST. *Adelington* WARD) *27*

2-FULL NAME

(Residence in Baltimore: No. *94 Copley Ave (see over)* St.; yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

*White*5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)*Married*

6-DATE OF BIRTH,

? *?* *1863*
(Month) (Day) (Year)

7-AGE,

59 *?* *?*
yrs. mos. ds.

If LESS than 1 day,

.... hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

OCT 27 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

10 - 25, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

*Oct 20 - 1912, to Oct 25 1922*that I saw her alive on *Oct 24 1922*and that death occurred, on the date stated above, at *530* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *E. E. Nichols* M. D.*10/25, 1922* (Address) *P. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Holy Family Cemetery

20-UNDERTAKER

J. F. Elnie

DATE OF BURIAL,

Oct. 28, 1922

ADDRESS

*Resurrection**m 4*

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. — WRITE PLAINLY, WITH UNFADING INK. THIS FORM SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Carver
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68667

CERTIFICATE OF DEATH.

D 68667

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.P.I.)

ST., 15 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Frank D. Carver

(a) RESIDENCE NO. 3037 W. North Ave.
(Usual place of abode)

ST., 15 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of Mrs. F. D. Carver

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1876

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
46 8 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work office manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER Frank J. Carver

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Virginia Fairchild

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs. Fannie Carver
(Address) 3037 W. North Avenue

15 Filed 19 ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 27, 1922

17 I HEREBY CERTIFY, That I attended deceased from October 26, 1922, to October 27, 1922, that I last saw him alive on October 27, 1922, and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

appendicitis, ruptured

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct. 27, 1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. B. Luce, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Lorraine Cemetery

10/30, 1922

20 UNDERTAKER

ADDRESS

Henry W. Hears & Son 805 N. Calvert

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68668

CERTIFICATE OF DEATH.

D 68668

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

Length of residence in city or town where death occurred

57 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

OCT 27 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

20 UNDERTAKER

ADDRESS

Henry W. Hears & Son 205 N. Calvert

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1517 N. Eden St., 9 Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. 1517 N. Eden St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Oct 26 1922 (Month) (Day) (Year)

7-AGE, If LESS than 1 day, 9 1/2 yrs., mos., ds. hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balt Md

10-NAME OF FATHER, Frederick H. Petersack

11-BIRTHPLACE OF FATHER, (State or Country), Balt Md

12-MAIDEN NAME OF MOTHER, Lillian Buchta

13-BIRTHPLACE OF MOTHER, (State or Country), Balt Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick H. Petersack

(Address) 1517 N. Eden Cr

15-OCT 27 1922 ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26 1922 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inanition - Pneumonia birth - 7 mos 9 days lived 9 1/2 hrs. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. H. Allen M. D. (Coroner) 10-27-22 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Baltimore Cemetery Oct 27 1922

20-UNDERTAKER, ADDRESS

Wesley Brooks & Son 1341 E. Eager St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68670

CERTIFICATE OF DEATH.

159-002 D 68670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 S. 2nd ST., 26 WARD)2-FULL NAME Catherine Ely Hess(a) RESIDENCE NO. 1308 S. 2nd ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 9, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md10 NAME OF FATHER Frank Hess11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)12 MAIDEN NAME OF MOTHER Margaret Mullany13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14

Informant (Address) Frank Hess 1308 S. 2nd St

15

Filed

OCT 27 1922

Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 9, 1922 to Oct 26, 1922, that I last saw her alive on Oct 26, 1922, and that death occurred, on the date stated above, at 3:50 P.M.

The CAUSE OF DEATH* was as follows:

Open Farcen Ovary(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? ObservationSigned Harvey B. Tilton M. D.26 1922 Address 315 S. Highland Ave

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

Oct 27 1922

20 UNDERTAKER

Lilly and Zeile

ADDRESS

403 S. W. 1st St.

N. B.—WRITE PLAINLY, WITH ONE WORD FOR EACH. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

068671

HEALTH DEPARTMENT—CITY OF BALTIMORE

068671

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 920 Wilmer Alley, St. 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 920 Wilmer Alley St.; yrs. 90 mos. 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female 4-COLOR OR RACE, colored 5-Single, Married, Widowed, or Divorced, single
(Write the word.)

6-DATE OF BIRTH, about 1832
(Month) (Day) (Year)

7-AGE, 90 yrs. 0 mos. 0 ds. If LESS than 1 day, 0 hrs. or 0 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, seamstress
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Wm. B. Smith

11-BIRTHPLACE OF FATHER, (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Anna Stule

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Anna Stule

(Address), 920 Wilmer Alley

15-

Filed

OCT 27 1922

ROBERT R. KRAUTER,
Bucial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral pneumonia

(Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY see history (Secondary)

(Signed) J. T. Heerens M. D. (Coroner)

Oct 27 1922 (Address) 282 E. Church St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, not buried DATE OF BURIAL, 10/27/22

20-UNDERTAKER, Mrs. R. A. Elliot ADDRESS, 1725 Highland

Physicians should state EXACTLY, Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1909 Bk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 S. Bond ST. 3 WARD)

2-FULL NAME

Novella Fuel

(a) RESIDENCE. NO. 405 S. Bond ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 15, 1912

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

10

6

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Charleston, W. C.

10 NAME OF FATHER

John Fuel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Charleston, W. C.

12 MAIDEN NAME OF MOTHER

Winnie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Charleston, W. C.

14

Informant (Address)

Winnie Fuel 405 S. Bond St.

15

Filed

OCT 27 1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/1922

17

HEREBY CERTIFY, That I attended deceased from 8/16/1922 to 10/26/1922 that I last saw him alive on 10/24/1922 and that death occurred, on the date stated above, at 12:10 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. 2 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Smith, M. D.

(Address) 1216 D. H. Ave.

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery Oct 29 1922

20 UNDERTAKER

Mrs Robert A. Elliott

ADDRESS

1735 Ashland St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68673

CERTIFICATE OF DEATH.

D 68673

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD) 38✓

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Madden

(a) RESIDENCE NO. Unknown

(Usual place of abode)

ST. _____ WARD _____

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -----

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE 47 Years Months Days If LESS than 1 day, hrs or min. -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Labr. 040

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Record,
(Address) Municipal Hospital.

15 Filed 1922 ROBERT R. KRAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 25 1922

17 I HEREBY CERTIFY, That I attended deceased from November 29, 1919 to October 25, 1922, that I last saw him alive on October 25, 1922, and that death occurred, on the date stated above, at 10:45 AM. The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 27 yrs. mos. ds.

CONTRIBUTORY Syphilitic aortic
(Secondary) insufficiency (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Reported

What test confirmed diagnosis? cf was. etc

(Signed) Clayde M. Neill M. D.

9/26/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laural Cemetery

DATE OF BURIAL

Oct 30 1922

20 UNDERTAKER

Mrs Robert A. Elliott

ADDRESS 1925

Ashland

By

Tagliavia

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68674

CERTIFICATE OF DEATH.

D 68674

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 Colvin ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Maria Tagliavia

(a) RESIDENCE NO.

418 Colvin St.

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

8 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

8 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofCarmelo Tagliavia

6 DATE OF BIRTH (month, day, and year)

1896

7 AGE

26 Years

Months

Days

If LESS than
1 day, hrs
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Italy

10 NAME OF FATHER

Antonio Cristofalo11 BIRTHPLACE OF FATHER (city or town)
(State or country)Italy

12 MAIDEN NAME OF MOTHER

Lidia Salerno13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Italy

14

Informant
(Address)Carmelo Tagliavia
418 Colvin St.

15

Filed

OCT 27 1922ROBERT R. KRAUTER,
Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 26 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 7 1922 to Oct 26 1922that I last saw him live on Oct 17 1922and that death occurred, on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Endocarditis
Mitral Regurgitation(duration) 2 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)Acute Cardiac Dilatation(duration) 2 hours

18 Where was disease contracted

if not at place of death? 0Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? None(Signed) Chas. E. Brumley, M. D.19 (Address) 412 Calhoun St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Sole Redeemer Cemetery

DATE OF BURIAL

10/28 1922

20 UNDERTAKER

George J. Ruth

ADDRESS

1735 Hanford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68675

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1649 E. Madison ST.,WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Pauline Dorothy Waller

(a) RESIDENCE NO.

1649 E. Madison

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female colored single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

no

6 DATE OF BIRTH (month, day, and year)

1917

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5 years

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Middle sex Va

10 NAME OF FATHER

William waaler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Susie Curtis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant

William waaler

(Address)

1649 E. Madison St

15

Filed

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-27-1922

17

I HEREBY CERTIFY, That I attended deceased from 10-26-1922, to 10-27-1922,that I last saw him alive on 10-26-1922,and that death occurred, on the date stated above, at 3, 15 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Gargis, M. D.10-27, 1922 (Address) 611-N-Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Middlesex Co. RdWester view OCT 30 1922

20 UNDERTAKER

ADDRESS

Eduard. Brjom1631
at
calcon

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 27 1922

Burial Permit Clerk

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Primary

D 68676

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

ST.

WARD

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST.

WARD

Length of residence in city or town where death occurred

56 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Margaret Brady

6 DATE OF BIRTH (month, day and year)

Sept. 29-1866

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

56

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

City Hall

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

Thomas R. Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind

12 MAIDEN NAME OF MOTHER

Margaret Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant (Address)

Margaret Brady 2047 E. Lombard

15

Filed

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 24 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1922, to Oct. 24, 1922.

that I last saw him alive on Oct. 23, 1922.

and that death occurred, on the date stated above, at 11:40 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 mos. ds.

CONTRIBUTORY (Secondary)

Rheumatism (duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Albert Charles M. D.

19 (Address) 1700 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cem 10/28/1922

20 UNDERTAKER

ADDRESS

J. A. Moran E. B. B. B.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 27 1922

D 68677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68677

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1710 E 28th ST., 9 WARD)2. FULL NAME Wesley C. Warren(a) RESIDENCE No. 1710 E. 28th ST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M4 COLOR OR RACE W5 Single, Married, Widowed, or Divorced, (write the word) Divorced5a If married, widowed or divorced HUSBAND of (or) WIFE of Mr. Bertha Dietz6 DATE OF BIRTH (month, day, and year) Feb 25 1870

7 AGE

Years 52Months 7Days 6

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor(b) General nature of industry, business, or establishment in which employed (or employer) Cond. Street R. Way(c) Name of employer United Railway9 BIRTHPLACE (city or town) Capeville Va.
(State or country)10 NAME OF FATHER Johna Warren11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)12 MAIDEN NAME OF MOTHER Ellen Virginia13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14

Informant Marion Warren
(Address) 1710 E 28th St

15

Robert F. Warren

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1922

17

I HEREBY CERTIFY, That I attended deceased from June 15 1922 to Oct 26 1922, that I last saw him alive on Oct 25 1922and that death occurred, on the date stated above, at 436 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs(duration) yrs. 10 mos. ds.CONTRIBUTORY (Secondary) Hearting & Measles
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? Usual(Signed) Edmund M. D.(Address) 1005 W North St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Western CemeteryDATE OF BURIAL Oct 28 192220 UNDERTAKER Robt J TurnerADDRESS 1442 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of O. C. U. P. A. TION is very important. See instructions on back of certificates.

OCT 27 1922

D 68678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *104 W. Barney*)ST. *23* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *104 W. Barney*

(Usual place of abode)

ST. *23* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *28* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Charles H. Baker*6 DATE OF BIRTH (month, day, and year) *Dec 19 1881*7 AGE Years *41* Months *10* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House keeping*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Va.*10 NAME OF FATHER *William Street*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Va.*12 MAIDEN NAME OF MOTHER *Ella Sadler*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Va.*14 Informant *Nannie Wells* (Address) *214 Post*15 Filed *Robert P. Harrison,* Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 25 1922*17 I HEREBY CERTIFY, That I attended deceased from *Oct 22 1922* to *Oct 25 1922*that I last saw *her* alive on *Oct 25 1922*and that death occurred, on the date stated above, at *4:20 p.m.*

The CAUSE OF DEATH* was as follows:

Carboid Hemorrhage

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *4*(duration) yrs. mos. ds. *2*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *R. P. Harrison*19 (Address) *1644 Hammond*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

61271922

Burial Permit Clerk.

D 68679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68679

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1012 Fawn*)ST. *3*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. *1012 Fawn*

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Dec 3 1896*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*25**10**6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Rose Reiger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

John Reiger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt

12 MAIDEN NAME OF MOTHER

Anna Verrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

St. Mary Balt

14

Informant (Address)

John Reiger

15 Filed

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 25 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct. 20*, 1922, to *Oct 24*, 1922, that I last saw her alive on *Oct. 24*, 1922, and that death occurred, on the date stated above, at *4 A.* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Robert J. Green*, M. D.25, 1922 (Address) *120 Acisquith St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Wendell D. Dyer**Oct 25 1922*

PHYSICIAN'S should state EXACTLY. Exact statement of OCCASION should be stated EXACTLY. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

127 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68680

D 68680

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Bay View Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Eastern Ave 12

ST., WARD)

2-FULL NAME

Pauline Goode

(a) RESIDENCE NO.

118W 23rd

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1887

7 AGE

35

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Weverly Goode

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Susan Goode

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

Municipal Hosp. Records

15

ROBERT P. HARRISON,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-25 1922

17

I HEREBY CERTIFY, That I attended deceased from

9-14 1922, to 9-25 1922

that I last saw her alive on 9-25 1922.

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Pyometria + bilateral salpingo-oophoritis over

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

Postoperative shock

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-24-22

Was there an autopsy? no

What test confirmed diagnosis?

Operation

(Signed) J. Richardson Jones, M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Evergreen Cem Oct 24 1922

20 UNDERTAKER

ADDRESS

Brown & Fickland

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

OCT 27 1922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Colon infection

D 68681

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68681

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2832 Harlem Ave. ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William Hood

(a) RESIDENCE NO.

2832 Harlem Ave.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mary Hood

6 DATE OF BIRTH (month, day, and year) Nov. 12th 1851

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

70

11

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Soldier)

(b) General nature of industry, business, or establishment in which employed (or employer) 20 years

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia
(State or country) Pa.

10 NAME OF FATHER John Hood

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Ann E. Allen

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Pa.14 Informant Mrs. Mary Hood
(Address) 2832 Harlem Ave.15 Filed Robert P. Harrison,
Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26th 19 22

17

I HEREBY CERTIFY, That I attended deceased from
Sept 19 1922 to Oct 26 1922.
that I last saw him live on Oct 25 1922.

and that death occurred, on the date stated above, at 8.30A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial
nephritis
(duration) yrs. mos. ds.CONTRIBUTORY (Secondary) Edema of Lungs
(duration) yrs. mos. ds.18 Where was disease contracted Place of death
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Thym. Exam
(Signed) John S. Mahan, M. D.

Oct. 26 1922 Address 1219 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn Cemetery

20 UNDERTAKER

Joseph B. Cook

DATE OF BURIAL

Oct 28 1922

ADDRESS

1003 N. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OCT 27 1922

Burial Permit Clerk.

D 68682

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68682

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Cleveland St., ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Edward Bell

(a) RESIDENCE No. 1122 Cleveland St., ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 29 1921

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 9 27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Charles A. Bell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie M. Bury

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Charles A. Bell (Address) 1122 Cleveland St.

15 Filed Robert F. Harris, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 19 22, to Oct 26, 19 22

that I last saw him alive on Oct 25, 19 22

and that death occurred, on the date stated above, at 2.35 P.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lob.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. Brumby, M. D.

10/26 22 Address 517 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

DATE OF BURIAL Oct 30 19 22

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 1/2 Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this form should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 27 1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68684

CERTIFICATE OF DEATH.

D 68684

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2133 Harford Ave ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Dorothy M. Bose

(a) RESIDENCE NO.

2133 Harford Ave ST. 8 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

2 mos.15 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 13-22

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.215

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)City

10 NAME OF FATHER

Geo. F. Bose11 BIRTHPLACE OF FATHER (city or town)
(State or country)Md.

12 MAIDEN NAME OF MOTHER

Lillian E. Hughes13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Md.

14

Informant
(Address)Geo. F. Bose
2133 Harford Ave

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 27 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct 25, 1922, to Oct 27, 1922.that I last saw her alive on Oct 26, 1922.and that death occurred, on the date stated above, at 12:45 A. m.

The CAUSE OF DEATH* was as follows:

Heart exhaustion(duration) X yrs. X mos. 1 ds.CONTRIBUTORY (Secondary) Bronchial overPneumonia (duration) X yrs. X mos. 2 ds.18 Where was disease contracted
if not at place of death? sameDid an operation precede death? No Date of NoWas there an autopsy? NoWhat test confirmed diagnosis? same(Signed) Far. L. Green, M. D.19 (Address) 748 So 30 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Trinity Cem. Oct 28 22

20 UNDERTAKER

Philip Henry 2016Oleander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 28-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68685

CERTIFICATE OF DEATH. *X 11-001*

D 68685

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Nursing and Childs Hosp 18* ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME *John William Hoile*(a) RESIDENCE NO. *612 Summit Ave Hagerstown Md* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *0* yrs. *2* mos. *20* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *infant.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct. 12, 22*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *0 15*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*10 NAME OF FATHER *Gardner Baggett*11 BIRTHPLACE OF FATHER (city or town) *Brimley Springs* (State or country) *W. Va.*12 MAIDEN NAME OF MOTHER *Penny Woodhead*13 BIRTHPLACE OF MOTHER (city or town) *Bloomington* (State or country) *Md.*14 Informant (Address) *George A. Hutton*15 Filed *Robert P. Harrison* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 27 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Oct 25 1922 to Oct 27 1922.*that I last saw him alive on *Oct 27 1922*and that death occurred, on the date stated above, at *3:15 A. m.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia (grippe infection)(duration) *0* yrs. *0* mos. *2* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *Walter F. Hough* M. D., 19 (Address) *1001 E. Pratt St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

George Smith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

1281922

D 68686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 E. Pratt St., 3 Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. 916 E. Pratt St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, white 5-Single, Married, Widowed, or Divorced. Single
(Write the word.)6-DATE OF BIRTH, Feb 8 1922
(Month) (Day) (Year)7-AGE, 8 19 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Infant
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), MD10-NAME OF FATHER, Jas Corran11-BIRTHPLACE OF FATHER, (State or Country), MD12-MAIDEN NAME OF MOTHER, Nellie Sellers13-BIRTHPLACE OF MOTHER, (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Corran(Address) 916 E. Pratt St15- Robert F. Battison,Filed 1922 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 27 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

EnterocolitisCONTRIBUTORY (Secondary) Shw 124 1922 MD(Signed) Shw 124 1922 MD
(Address) Curtis Bay*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal. Kalton, Md18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Trinity Cemetery Oct 28 1922

20-UNDERTAKER, ADDRESS

John A. Moran 3400 E. Balt

M. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

D 68687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68687

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2727 Hampden ST., 12 WARD)

2. FULL NAME

Helen Virginia Strwig

(a) RESIDENCE NO.

2727 Hampden ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W5 Single, Married, Widowed,
or Divorced, (write the word)Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 7, 1916

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.6

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltmd.

10 NAME OF FATHER

Walter H. Strwig

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

md.

12 MAIDEN NAME OF MOTHER

Volva B. Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

md.

14

Informant
(Address)Volva B. Harris
2727 Hampden Ave.

15

Name

Robert P. Harrison,

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 26, 1922, to Oct. 28, 1922.that I last saw her alive on Oct. 27, 1922.and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Laryngeal Diphtheria

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Machin, M. D.19 (Address) 4037 Falls Road*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVALGraves Run Carroll Co.

20 UNDERTAKER

Chenoweth & Son

DATE OF BURIAL

10/29, 19 22

ADDRESS

301

D 68688

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2437 Lakeview Ave WARD) 13

2-FULL NAME

(Residence in Baltimore: No. Grenada Apart 2437 Linden Ave St.; 21 yrs., mos. ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Divorced

6-DATE OF BIRTH,

Jan 8, 1877
(Month) (Day) (Year)

7-AGE,

45 yrs. 1 mos. 18 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Clerk

9-BIRTHPLACE, (State or Country),

Brazil

10-NAME OF FATHER,

Squire Sampson

11-BIRTHPLACE OF FATHER (State or Country),

Penn

12-MAIDEN NAME OF MOTHER

Laura Porter

13-BIRTHPLACE OF MOTHER (State or Country),

Alabama

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mary E. Sampson
Grenada Apart

15-

Robert F. Harrison

Filed

191

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 26, 1922
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from August 3 1922, to Oct 26 1922, that I saw him alive on Oct 24 1922, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Sciatica(Duration) ... yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) George M. Smith M. D.Oct 26, 1922 (Address) 2435 Maryland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

London Park Oct 28, 1922

20-UNDERTAKER

ADDRESS

John Mitchell 1200 W. Thayer

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68689 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68689

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *7* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *William Sweeney*

(Residence in Baltimore: No. *Sellers Mrs* St. *25* yrs. *3* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* *Single, Married, Widowed, Divorced* (Write the word.)

6-DATE OF BIRTH *Feb 14* 18*85* (Month) (Day) (Year)

7-AGE *65* yrs. *5* mos. *11* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *Seaman* (b) General nature of industry, business, or establishment in which employed (or employer) *086*

9-BIRTHPLACE (State or Country) *L.I. N.Y.*

PARENTS: 10-NAME OF FATHER *unknown* 11-BIRTHPLACE OF FATHER (State or Country) *N.Y.* 12-MAIDEN NAME OF MOTHER *unknown* 13-BIRTHPLACE OF MOTHER (State or Country) *N.Y.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) *Marie Sweeney* (Address) *130 N. Chase St*

15- Filed *Robert F. Harrison* 19*22* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *October 25* 19*22* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* find that said deceased came to *his* death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows: *Abdominal Hemorrhage due to rupture of transverse colon & abd. wall abd. aorta. Accidental* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *none* (Signed) *J. H. Sellers* M. D. (Coroner.) 10-*27* 19*22* (Address) *508 E. Mount*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Baltimore Cemetery Oct 28* 19*22*

20-UNDERTAKER, ADDRESS *Harry H. Witzke 15310 Lombard St.*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68690 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68690

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 716 N. Bond St., 147 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Brooks

(Residence in Baltimore: No. 654 W. Hoffman St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Black 5-Single, Married, Divorced, or Widowed (Write the word.)

6-DATE OF BIRTH, March 1876 (Month) (Day) (Year)

7-AGE, 46 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Domestic (b) General nature of industry, business, or establishment in which employed (or employer), 070

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, Eldridge Brooks

11-BIRTHPLACE OF FATHER, Va

12-MAIDEN NAME OF MOTHER, Maggie Wallon

13-BIRTHPLACE OF MOTHER, Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), George H. Hallman

(Address), 1631 David Hill Ave

15- Robert P. Harrison, Registrar

Filed, 1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 26, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (Arteriosclerosis)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Indigestion

(Signed) J. H. Hallman M. D.

(Coroner.)

10-27-22 1922 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Ind Auburn City, Oct 27 1922

20-UNDERTAKER, ADDRESS

George H. Hallman, 1631 David Hill Ave

D 68691

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68691

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 15786 Clifton Ave 3 WARD)

2. FULL NAME

(a) RESIDENCE NO. 15786 Clifton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds.How long in U. S., if of foreign birth 48 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1922, to Oct. 27, 1922. That I last saw him alive on Oct. 21, 1922.

and that death occurred, on the date stated above, at 3:45 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma (face)

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) H. N. Sisco M. D.

, 19 (Address) 1315 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Burial Permit Clerk

D 68694 HEALTH DEPARTMENT--CITY OF BALTIMORE D 68692

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 327 Otterbein ST. WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. 327 Otterbein St. 40 yrs. mos. da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-STATUS

WIDOWED
(Write the word.)

6-DATE OF BIRTH

unknown, 1836
(Month) (Day) (Year)

7-AGE

86

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE
(State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER
(State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

Oct 26, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 - 1912 to Oct 26, 1922

that I saw her alive on Oct 25, 1922

and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) John G. Schwenke M. D.
Address 1176 W. 11th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Auburn

Oct 28, 1922

20-UNDERTAKER

ADDRESS

John H. Tradner Hill

142

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68693

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N. Calvert St ST. 12 WARD)2-FULL NAME Elizabeth Gertrude O'Neill(a) RESIDENCE NO. 1618 N. Calvert ST. 12 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9 - 18677 AGE Years Months Days If LESS than 1 day, hrs or min. abt. 55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed Oct 28 1922

Burial Permit Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1922

17

I HEREBY CERTIFY, That I attended deceased from April, 19 22, to Oct 26, 19 22.that I last saw him alive on Oct 26, 19 22.and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-Renal disease(duration) 5 yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 3 mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Examination(Signed) George H. Gorn, M. D., 19 (Address) 1000 E. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cathedral Cemetery10/30, 1922

20 UNDERTAKER

ADDRESS

Henry W. Mears & Son 805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68694

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68694

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2702 Edmondson ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William A. Lamp

(a) RESIDENCE NO. 2702 Edmondson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? 56 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Madeleine Lamp

6 DATE OF BIRTH (month, day, and year) Feb. 27 1860

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

62 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Dry Cleaner

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Someborn & Son

9 BIRTHPLACE (city or town)
(State or country)

Germany

10 NAME OF FATHER

John A. Lamp

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Bertha Schmidt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)Carl Lamp
2702 Edmondson A

15

Robert F. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 19 22, to Oct 27, 19 22,

that I last saw him alive on Oct 27, 19 22,

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

W. H. C. of

M. D.

(Address) 54 Mulberry Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Woodlawn OCT 30 1922

20 UNDERTAKER

ADDRESS

Geo W. Little 2700
EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 28 1922

D 68695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68695

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Municipal Tuberculosis Hospital

ST.,

WARD)

2-FULL NAME Edward Burke

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 328 S. Caroline st.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

Colored

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country)

Pennsylvania

10 NAME OF FATHER

John Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER Mary Hilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pennsylvania

14

Informant (Address)

Hospital Records

Robert P. Harrison,

15

Filed

19

Burial Permit Clerk:

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1922, to Oct. 23, 1922,

that I last saw him alive on Oct. 23, 1922,

and that death occurred, on the date stated above, at 6.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, x-ray

(Signed)

J. A. M. Carey, M. D.

10-24-22

19

(Address) Municipal Th. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

UNIVERSITY OF MARYLAND.

ADDRESS

20 UNDERTAKER

Commissioner Health,

Prof. Wm. S. WOODALL

B. B. — WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

6328 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every statement should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE
D 68696 100-001 D 68696
CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD)
2-FULL NAME Thomas Caufield
(a) RESIDENCE NO. Unknown ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced, (write the word) <u>Single</u>		
5a If married, widowed, or divorced HUSBAND of <u>---</u> (or) WIFE of <u>---</u>				
6 DATE OF BIRTH (month, day, and year) <u>1857</u>				
7 AGE <u>65</u>	Years	Months <u>--</u>	Days	If LESS than 1 day, hrs or min.
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <u>Wood Turner</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>014</u> (c) Name of employer				
9 BIRTHPLACE (city or town) <u>Baltimore,</u> (State or country) <u>Maryland</u>				
10 NAME OF FATHER <u>Unknown</u>				
11 BIRTHPLACE OF FATHER (city or town) <u>Unknown</u> (State or country)				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
13 BIRTHPLACE OF MOTHER (city or town) <u>Unknown</u> (State or country)				

14 Informant Municipal Hospital Records
(Address)
15 Filed Robert F. Harrison, 19 1922
Registrar

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH (month, day, and year) <u>Oct. 26 19 22</u>	
17 I HEREBY CERTIFY, That I attended deceased from <u>November 5, 19 16</u> to <u>October 26, 19 22</u> , that I last saw him alive on <u>October 25, 19 22</u> , and that death occurred, on the date stated above, at <u>9:30 A.M.</u> The CAUSE OF DEATH* was as follows: <u>Broncho pneumonia</u> (duration) yrs. mos. <u>3</u> ds. CONTRIBUTORY (Secondary) <u>Arteriosclerosis</u> (duration) <u>5</u> yrs. mos. ds. 18 Where was disease contracted if not at place of death? Did an operation precede death? Date of Was there an autopsy? <u>No</u> What test confirmed diagnosis? (Signed) <u>Clifford Harrison</u> , M. D. <u>10/26/22</u> (Address) <u>Municipal Hospital.</u> *State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) 19 PLACE OF BURIAL, CREMATION OR RE- MOVAL <u>UNIVERSITY OF MARYLAND.</u> DATE OF BURIAL 20 UNDERTAKER <u>Commissioner Health,</u> ADDRESS <u>1922</u>	

081281922 Burial Permitted 1922

D 68697

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68697

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 17 WARD)2-FULL NAME George D. Croxton or Geo. Davidson

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 556 Preston st.ST. 17 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19037 AGE Years 19 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland10 NAME OF FATHER Thornton Croxton11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Susie Brokenberg13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

PARENTS

14 Informant Hospital Records (Address) M.T.H.15 Robert F. HarrisonFiled 19618

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 23, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 4, 19 22, to Oct. 23, 19 22.that I last saw him alive on Oct. 23, 19 22.and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 9 yrs. mos. ds.18 Where was disease contracted Unknown if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? T. in sputum, X-ray(Signed) Francis J. Padayachee M. D.10-24-22 (Address) Municipal The. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL OCT 25 1922

20 UNDERTAKER

ADDRESS

Commissioner Health,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 6869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-D 68698

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Franklin D. Roosevelt Hospital* ST. 19 WARD)2-FULL NAME *Melvin L. Stinefelt*(Residence in Baltimore: No. *338 Fulton Ave*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*4-COLOR OR RACE *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *Oct 22, 1912*

(Month)

(Day)

(Year)

7-AGE,

yrs. mos. 4 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,

(State or Country), *Balt Md*

PARENTS.

10-NAME OF FATHER, *Melvin L. Stinefelt*11-BIRTHPLACE OF FATHER (State or Country), *Balt. Md*12-MAIDEN NAME OF MOTHER *Anna Charlton*13-BIRTHPLACE OF MOTHER (State or Country), *Balt Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Anna Stinefelt*(Address) *33 S. Fulton Ave.*

15-

Robert P. Harrison,

Filed

191

Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 27, 1912*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 22, 1912*, to *Oct 27, 1912*,that I saw him alive on *Oct 26, 1912*and that death occurred, on the date stated above, at *1:45* p.m.

The CAUSE OF DEATH* was as follows:

Heart failure due to coronary artery disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *M. D.*10:21, 1912 (Address) *33 S. Fulton Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 4 ds. In the State yrs. mos. 4 ds.

Where was disease contracted, if not at place of death? *At place of death*

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Loudon Park Cemetery

20-UNDERTAKER

George L. Schwab

DATE OF BURIAL,

Oct. 28, 1912

ADDRESS

2101 Fredk. Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

CT 28 1922

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68699

CERTIFICATE OF DEATH.

D 68699

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

Name of

(or wife of)

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw alive on and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous nephritis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 68700

CERTIFICATE OF DEATH.

D 68700

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1915 E. Lafayette ST., 8 WARD)

2-FULL NAME

(a) RESIDENCE No. 1915 E. Lafayette ST.,

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Joseph Garland6 DATE OF BIRTH (month, day, and year) Feb. 4, 1849

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

73822

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

self

9 BIRTHPLACE (city or town) (State or country)

Millicentown
St. Mary Co. Md

10 NAME OF FATHER

Wm Mattingly

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Maria Long

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Beatrice Reutschler
1915 E. Lafayette Ave

15

Robert F. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1922

17

I HEREBY CERTIFY, That I attended deceased from March 1, 1922, to Oct 26, 1922.that I last saw her alive on Oct 24, 1922.and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of Was there an autopsy? noWhat test confirmed diagnosis?

(Signed)

E. J. Burton

M. D.

1927/1922 (Address) 301 E. 6th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Cedar Hill10-30 1922

20 UNDERTAKER

ADDRESS

Est B. Harle115 E. 2nd St

N. B. -- WRITE PLAINLY, WITH UNFADING INK -- THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 68701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hebrew Hospital*

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.: 7 WARD)

2-FULL NAME *Mollie Sperling*

(a) RESIDENCE. NO. *Washington St*

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Autumn*

7 AGE Years *56* Months *-* Days *-* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Poland* (State or country)

10 NAME OF FATHER *Aaron Sperling*

11 BIRTHPLACE OF FATHER (city or town) *Poland* (State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Poland* (State or country)

14 Informant *Aaron Sperling* (Address) *722-4th St. S.W. Wash D.C.*

15 *Oct 29 1922* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/28/22*

17 I HEREBY CERTIFY, That I attended deceased from *Oct 15*, 19*22*, to *Oct 28*, 19*22*, that I last saw her alive on *Oct 28*, 19*22*, and that death occurred, on the date stated above, at *10 A* m.

The CAUSE OF DEATH* was as follows:

1 Chronic Ulcerative Colitis
2 Chronic Nephritis

(duration) yrs. *7* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*

Was there an autopsy?

What test confirmed diagnosis? *Stool-Urine-Blood* (Signed) *Ernest Edlertch*, M. D.

10-28-1922 (Address) *Hebrew Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Mt Carmel

Oct 29 1922

20 UNDERTAKER

ADDRESS

Max Linnson

1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10 21—M&T—1500 Bks.

68702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

68702
90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Patapsco St.

ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emilie Liedtke

(a) RESIDENCE No. 1435 Patapsco St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 58 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Frederick Liedtke

6 DATE OF BIRTH (month, day, and year) Feb. 19 1844

7 AGE Years 78 Months 8 Days 8 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Christian Steigraber

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Caroline Bayer

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mr. Sherwood (Address) 1435 Patapsco St.

15 OCT 29 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1922, to Oct 27, 1922.

that I last saw him alive on Oct 27, 1922.

and that death occurred, on the date stated above, at 6:40 p.m.

The CAUSE OF DEATH* was as follows:

Arterial degeneration

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. McConally, M. D.

2, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park Cemetery

DATE OF BURIAL

Oct. 30 1922

20 UNDERTAKER

J. H. McConally

ADDRESS

1305 Ford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68703

D 68703

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Maryland General Hospital*
CITY OF BALTIMORE: (No. *Madison & Linde Ave* ST. *Baltimore* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Henrietta Treakele*

(a) RESIDENCE NO. *Palmer Virginia* ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *J. Arthur Treakele*

6 DATE OF BIRTH (month, day, and year) *May 22 1879*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *43 7 7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Brownsville Co* (State or country) *Maryland*

10 NAME OF FATHER *F. H. Treakele*

11 BIRTHPLACE OF FATHER (city or town) *Brownsville Co* (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Adeline J. Coulbourn*

13 BIRTHPLACE OF MOTHER (city or town) *Brownsville Co* (State or country) *Maryland*

14 Informant *J. A. Treakele* (Address) *Palmer, Va.*

15 *ROBERT H. KRAUTER,* Registrar
Filed OCT 29 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 29 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct. 28* 19 *22* to *Oct 29* 19 *22*, that I last saw her alive on *Oct. 29* 19 *22*, and that death occurred, on the date stated above, at *12:15 A.* m. The CAUSE OF DEATH* was as follows:

Incorrelated Ventral Hernia

CONTRIBUTORY (Secondary) *Intestinal Obstruction* (duration) yrs. mos. ds. *3*

(duration) yrs. mos. ds. *3*

18 Where was disease contracted *at home* if not at place of death?

Did an operation precede death? *Yes* Date of *10/28/22*

Was there an autopsy? *No*

What test confirmed diagnosis? *Post-mortem* (Signature) *M. D.*

19 (Address) *M. D. General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Whitestone, Va.

10/31 1922

20 UNDERTAKER

ADDRESS

Wm. J. Tichner Son

North Penn Ave

D 68704

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68704

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

1642 Abbott

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Josephina Hazecky

(a) RESIDENCE. NO.

1642 Abbott

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 30 1846

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

76

3

8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

And known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

And known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Catherine Hazecky 1642 Abbott

15

OCT 23 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 28 1922

17

HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to Oct 28, 1922

that I last saw him alive on Oct 27, 1922

and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Frank Spittler

over

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Microscopic exam.

(Signed) J. J. [Signature], M. D.

, 19 (Address) 1145 [Address]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Oct 28 1922

20 UNDERTAKER

ADDRESS

Hendell & Appel 375 M

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D 68705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

73 D 68705

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Tenaces Mt Washington* WARD)

2-FULL NAME

(Residence in Baltimore: No. *Tenaces Mt Washington* St. *12* yrs., *1* mos., *ds.*)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OF RACE.

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Married*

6-DATE OF BIRTH.

July 3, 1862
(Month) (Day) (Year)

7-AGE.

62 yrs., *3* mos., *24* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Artist*
(b) General nature of industry, business, or establishment in which employed (or employer) *out*

9-BIRTHPLACE, (State or Country),

Phila. Pa.

10-NAME OF FATHER,

Henry Whiteman

11-BIRTHPLACE OF FATHER (State or Country),

Ind.

12-MAIDEN NAME OF MOTHER

Mary Sibley

13-BIRTHPLACE OF MOTHER (State or Country),

Ind.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Katherine R. Whiteman*

(Address) *Tenaces Mt Washington*

15-

OCT 29 1922

ROBERT R. KRAUTER

Filed.....

101.....

Burial Permit

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Oct 27, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Dec 21, 1921*, to *Oct 27, 1922* that I saw him alive on *Oct. 27, 1922*, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralytic Agitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Adema (Duration) yrs. mos. ds.

(Signed) *W. H. Smith* M. D.

Oct. 29, 1922 (Address) *3429 Chestnut St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Phila. Pa.

DATE OF BURIAL,

Oct 30, 1922

20-UNDERTAKER

Shaw & Mitchell

ADDRESS

1201 N. Myrtle St.

D 68706

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68706

CERTIFICATE OF DEATH. *N/18-002*

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mayland General Hospital* ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. *Home de Grace Md.* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Archer M. Botts*6 DATE OF BIRTH (month, day, and year) *Oct-16 1871*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Harford Co.*10 NAME OF FATHER *John Northington*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md.*12 MAIDEN NAME OF MOTHER *Sarah C. Nelson*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14

Informant (Address) *Archer M. Botts*
Home de Grace Md.

15

Fact

OCT 29 1922 ROBERT B. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 29 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 28*, 1922, to *Oct 29*, 1922,that I last saw him alive on *Oct 29*, 1922,and that death occurred, on the date stated above, at *3:45 A.* m.

The CAUSE OF DEATH* was as follows:

*1. Fecal Fistula*CONTRIBUTORY (Secondary) *Intestinal Obstruction* (duration) yrs. mos. ds.18 Where was disease contracted *at home* if not at place of death?Did an operation precede death? *No* Date of *Oct 27 1922*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *James Hubert Williams*, M. D.(Address) *Md. General Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Home de Grace Md. *Oct 31 1922*
John Mitchell

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D 68707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68707

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Golda Levin

(a) RESIDENCE.

2020 W Christian

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Abraham Levin

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Ben Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant

(Address)

Jack Lewis 1439 E. Baltimore

15

Filed

19

ROBERT R. KRAUTER,

Registrar

OCT 29 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 25 1922 to Oct 29 1922

that I last saw her alive on Oct 29 1922

and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY

(Secondary)

Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Moses Selman M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bls.

D 68708

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 6 Fayette ST. 5 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 1120 6 Fayette ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 7 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 27 22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Dr. Caplan

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Ethel Leoni

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Jack Lewis (Address) 1439 53rd St. X

15 Filed OCT 29 1922 REGISTRAR B. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 22 to Oct 27 22, that I last saw him alive on Oct 27 22, and that death occurred, on the date stated above, at 9 A. m. The CAUSE OF DEATH* was as follows:

Remains in situ

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. J. Sawyer, M. D.

1021 24 Address) 210 14th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Wesleyan Church Cem 10/29/22

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 53rd St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68709

CERTIFICATE OF DEATH.

D 68709

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 N. Chapel ST., 7 WARD)

2-FULL NAME

(a) RESIDENCE NO. 1003 N. Chapel ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15, 1921

7 AGE Years 1 Months 5 Days 13 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER James Starkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Erene Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant James Starkey (Address) 1003 N. Chapel

15 Filed OCT 29 1922 ROBERT H. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1922, to Oct 28, 1922.

that I last saw him alive on Oct 28, 1922.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Ulcerative Stomatitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY Convulsions (Secondary) (duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallis W. White, Jr. M.D. (Address) 2800 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Baltimore

DATE OF BURIAL

Oct 30 1922

20 UNDERTAKER

Jirkler & Jirkler ADDRESS 739
Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68710

CERTIFICATE OF DEATH.

D 68710

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Hebrew Hospital*)

ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Ms. Carolyn Dornberg

(a) RESIDENCE No. *1335 W. North Ave*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Lifetime*

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Louis Dornberg

6 DATE OF BIRTH (month, day, and year)

Sept. 16, 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balti. Md.

10 NAME OF FATHER

Solomon Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Lee Dornberg 231 E. 25th St.

15

Filed

Oct 29 1922

ROBERT R. KRASTER Registrar

Burial Permit Clock

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10/28 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *before 22*, 19 *22*, to *October 28*, 19 *22*.

that I last saw him alive on *before 28*, 19 *22*.

and that death occurred, on the date stated above, at *4* *P* m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. *2* ds.

CONTRIBUTORY (Secondary)

Broncho pneumonia

(duration) yrs. mos. *17* ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed) *W. Ziemer*, M. D.

10/28, 1922 (Address) *1802 E. Balto. St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Friendship Co.

10/30/1922

20 UNDERTAKER

David Sondheim 118 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

OCT 29 1922

ROBERT R. KRAUER Registrar

C. J. Francis Mortuary

ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1922 to Oct 27, 1922 that I last saw him alive on Oct 27, 1922 and that death occurred, on the date stated above, at 2:05 P. m.

The CAUSE OF DEATH* was as follows:

Syngomyelia

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

Address Municipal Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68712

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Inf. ST. 15 WARD)

2-FULL NAME

Mrs. Olga C. Griffith

(a) RESIDENCE NO.

3307

Carlisle Avenue ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Robert E. Lee Griffith,

6 DATE OF BIRTH (month, day, and year) April 27, 1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

57

6

1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Frederick Co. Md.

10 NAME OF FATHER Garrison Warfield,

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Caroline Lewis,

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Frederick Co. Md.

14

Informant

Robert E. L. Griffith,

(Address)

3307 Carlisle Ave.

15

Filed

OCT 29 1922 ROBERT R. KRAUTER

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 48 19 22

17

I HEREBY CERTIFY, That I attended deceased from

OCT 26th, 19 22, to OCT 28th, 19 22.

that I last saw her alive on OCT 28th, 19 22.

and that death occurred, on the date stated above, at 8⁰⁰ P. M.

The CAUSE OF DEATH* was as follows:

Carcinomatosis ("Carcinoma of Stomach")

(duration)

2 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

1 yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of OCT 26th, 19 22

Was there an autopsy?

What test confirmed diagnosis?

Operation & Path. Findings

(Signed)

Richard S. Collier, M. D.

(Address)

Church Home & Inf. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

MOVAL

Lorraine

20 UNDERTAKER

Geo W Little

DATE OF BURIAL

OCT 31 19 22

ADDRESS

2700 EDMONDSON AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68713
D 68713
CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1503 Henry ST. 24 WARD) REGISTERED NO. 90
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
2-FULL NAME William Edward Kane
(a) RESIDENCE. No. 1503 Henry ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 Single, Married, Widowed, or Divorced (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of		
6 DATE OF BIRTH (month, day, and year) Oct. 3, 1854		
7 AGE 64	Years —	Months 23
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Can-Maker (b) General nature of industry, business, or establishment in which employed (or employer) Am. Can. Co. (c) Name of employer		
9 BIRTHPLACE (city or town) (State or country) Baltimore		
10 NAME OF FATHER Wm. J. Kane		
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland		
12 MAIDEN NAME OF MOTHER Mary Cusson		
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland		
14 Informant (Address) Mrs. Elliott 1503 Henry St.		

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/26/22

17 I HEREBY CERTIFY, That I attended deceased from 10/25/22 19 to 10/26/22 19 that I last saw him alive on 10/26/22 19 and that death occurred, on the date stated above, at 8:10 a. m.
The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
Auricular fibrillation
do not know
(duration) yrs. mos. ds.
CONTRIBUTORY Cardiac Dilatation
(Secondary) (duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical Examination
(Signed) J. Edward Norris, M. D.
10/26/22 (Address) 1430 Riverside Ave.
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 OCT 29 1922 ROBERT R. KRAUTER Registrar
19 PLACE OF BURIAL, CREMATION OR REMOVAL
Cathedral Cem.
20 UNDERTAKER
Margaret P. Flynn
DATE OF BURIAL
Oct 30 1922
ADDRESS
1422 Eglr St.

D 68714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68714

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

University Hospital

CITY OF BALTIMORE (No.

Lombard & Green

ST. 1

WARD)

2-FULL NAME

Stephen W Duckett

(a) RESIDENCE. NO.

Davidsonville Md.

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

12 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Mrs S W Duckett

6 DATE OF BIRTH (month, day, and year)

1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

71 years

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Farmer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Farmer

(c) Name of employer

Self

9 BIRTHPLACE (city or town)
(State or country)

Maryland

10 NAME OF FATHER

James E. Duckett

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Martha Harrey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant
(Address)Mrs Stephen W Duckett
Davidsonville Md.

15

Filed OCT 29 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29-22

17

I HEREBY CERTIFY, That I attended deceased from

10/17/1922, to 10/29/1922

that I last saw him alive on 10/29/1922

and that death occurred, on the date stated above, at 8:35 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Carcinoma of Rectum

(duration) unknown ds.

18 Where was disease contracted

if not at place of death? Davidsonville Md.

Did an operation precede death? yes Date of 10/23/22

Was there an autopsy? no

What test confirmed diagnosis? Clinical Tests

(Signed) Lynn Drumback M. D.

, 19 (Address) University Hopt.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Camp Parole Md 10-29-22

20 UNDERTAKER

ADDRESS

E & B Harb 115 West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68715

CERTIFICATE OF DEATH.

74-001

D 68715

1-PLACE OF DEATH

CITY OF BALTIMORE: No 2404 Druid Hill Avenue 13 WARD

2-FULL NAME

Rose V Connolly

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No

2404, Druid Hill Avenue

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Bernard Connolly

6 DATE OF BIRTH (month, day, and year)

Sept 14 1873

7 AGE

Years

Months

Days

If LESS than
1 day. hrs.
or min.

49

1

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

Home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore City

10 NAME OF FATHER

Mr Short

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Elkton

12 MAIDEN NAME OF MOTHER

Anna E. Romero

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore City

14

Informant
(Address)Bernard Connolly
2404 Druid Hill Avenue

15

Filed OCT 29 1922

ROBERT R. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 27 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct 14 1922 to Oct 27 1922
that I last saw him alive on Oct 27 1922
and that death occurred, on the date stated above, at 9:05 P. M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. 3 ds.

CONTRIBUTORY
(Secondary)

Chronic Myocarditis

(duration) 1 yr. 4 mos. 3 ds.

18 Where was disease contracted
if not at place of death?

At home

Did an operation precede death? In Date of

Was there an autopsy?

What test confirmed diagnosis?

Clinical

(Signed)

Wm. J. Hume

M. D.

10/29/1922 Address

1701 N. Union Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem

10/30 1922

20 UNDERTAKER

ADDRESS

J. J. Haley & Sons

1318 E. Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 68716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D 68716

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1233 James St - 21* ST. *21* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Domenica Chioldi*

(a) RESIDENCE. No. *1233 James St -* ST. *21* WARD.

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. *3* mos. *22* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 5 - 1922*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *3 22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*

10 NAME OF FATHER *Giuseppe Chioldi*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Italy*

12 MAIDEN NAME OF MOTHER *Mary Vincenza*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Italy*

14 Informant *Mrs. Giuseppina Chioldi* (Address) *1233 James St -*

15 Filed *29 1922* ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 28 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Oct. 22nd* to *Oct. 28th*, 19 *22*

that I last saw her alive on *Oct. 28th*, 19 *22*

and that death occurred, on the date stated above, at *7 p.* m.

The CAUSE OF DEATH* was as follows:

ant. gastro-enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Charles J. Costa*, M. D.

, 19 (Address) *30 Pearl St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Most Holy Redeemer Cem. Oct 30th 1922

20 UNDERTAKER ADDRESS

John J. Cawson 901 Hall's St

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68717

CERTIFICATE OF DEATH.

D 68717

1-PLACE OF DEATH

CITY OF BALTIMORE No. 2339 Eastern Ave ST. 1 WARD)

2-FULL NAME

Margaret Rolfe

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No.

2339 Eastern Ave ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs. 9

mos. 14

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 9, 1902

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

9 mos 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Frank H. Rolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Mary J. Jagielska

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Frank H. Rolfe 2339 Eastern Ave

15

Filed

OCT 29 1922

ROBERT H. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 27, 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 4, 19 22, to Oct 27, 19 22, that I last saw her alive on Oct 27, 19 22,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. P. Hooper, M. D.

19 PLACE OF BURIAL, CREMATION OR REMOVAL

1922 Address 346 E 18

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Holy Rosary

DATE OF BURIAL

Oct 30 19 22

UNDERTAKER

William Gialkowski Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68718

D 68718

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 S Broadway ST., 2 WARD)

2-FULL NAME

Walter Hepner

(a) RESIDENCE NO. 604 S. Broadway ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not married

6 DATE OF BIRTH (month, day, and year) Jan. 19, 1899

7 AGE Years 23 Months 9 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Michael Hepner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Amelia Bochnak

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Michael Hepner
604 S. Broadway

15

Filed

OCT 23 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1922

17

I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1920, to Oct. 28, 1922, that I last saw him alive on Oct 28, 1922, and that death occurred, on the date stated above, at 6.35 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

CONTRIBUTORY (Secondary)

(duration) yrs. 10 mos. 14 ds.

(duration) yrs. 5 mos. 5 ds.

18 Where was disease contracted

if not at place of death?

Place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed)

Edward R. Johnson, M. D.

(Address) 1212 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Rosary

Nov 2 1922

UNDERTAKER

ADDRESS

Wm. Frankowski 1618 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D 68719

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68719

38

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

Altoona Home

ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

David Orre

(a) RESIDENCE. NO.

Altoona Retreat - as a patient ST. 28

WARD.

Altoona, Pa.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 0 ds. How long in U. S., if of foreign birth? 30 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married-

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mrs. Orre

6 DATE OF BIRTH (month, day, and year)

About 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Electric Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

Machine work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Felldaysburg Pa

10 NAME OF FATHER

John Orre

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania Pa

12 MAIDEN NAME OF MOTHER

Clara Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Muncie Pa

14

Informant (Address)

Records of Altoona Retreat

15

OCT 29 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 26 1920, to Oct 29 1922

that I last saw him alive on Oct 25 1922

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Paresis

abs

(duration) 2 yrs. 2 mos. 14 ds.

CONTRIBUTORY

(Secondary)

Puritic Dementia

abs

(duration) 2 yrs. 2 mos. 14 ds.

18 Where was disease contracted

if not at place of death?

Altoona Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

19 (Address) Altoona Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Altoona - Penna

Oct 30 1922

20 UNDERTAKER

STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Owner)

ADDRESS

108 W. NORTH AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68720

CERTIFICATE OF DEATH.

90 D 68720

1-PLACE OF DEATH

City of BALTIMORE: (No. 1424 Clarkson St. St. 23 Ward)

Registered No. C.....

2-FULL NAME..... Ella Thomas. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1014 Peach Alley. St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced. (Write the word.)
Female. Colored. Widowed.

6-DATE OF BIRTH, Do not know. 1. (Month) (Day) (Year)

7-AGE, 44 yrs. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Domestic.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Chestertown, Md.

10-NAME OF FATHER, Henry Miller. C.

11-BIRTHPLACE OF FATHER, (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER, Arrie Goldsborough.

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Toy. (sister)

(Address) 919 Leadenhall St.

15- OCT 30 1922 ROBERT H. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 25th. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to her death on the day stated above. The CAUSE OF DEATH* was as follows:
Valvular disease of the heart.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signature) Otto M. Reinhardt, M. D. (Coroner) 1014 E. Charles St. Oct 27 1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Chester Town Md Oct 30 1922

20-UNDERTAKER, ADDRESS Mrs Robert A Elliott Ashland Ave

MARGIN RESERVED FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D 68721

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View Hospital* WARD)

2-FULL NAME

Mary Lee

(a) RESIDENCE NO.

609 Mosher St

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fem.

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

?

6 DATE OF BIRTH (month, day, and year)

1862

7 AGE

60

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Charity Hecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mary Hallie

1609 Mosher St

15

Filed

OCT 30 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 26 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Octob. 1*, 19*22* to *Octob 26*, 19*22*, that I last saw her alive on *Octob 26*, 19*22*, and that death occurred, on the date stated above, at *5:35 p. m.* The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY *Senile dementia* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

?

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed) *H. J. McDermott*, M. D.

(Address) *1704 Green St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Int. Aurlon Cem

DATE OF BURIAL

Oct 31, 1922

20 UNDERTAKER

Mrs Robert J. Elliott

ADDRESS

1715 Ashland St

MARGIN RESERVED FOR OFFICIAL USE
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 68722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001
REGISTERED NO.

D 68722

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 A Gilmore ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 218 A Gilmore ST., _____ WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Surie T Lawson

6 DATE OF BIRTH (month, day, and year) Oct 16 1857

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
65 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

John T Lawson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md

12 MAIDEN NAME OF MOTHER

Evelyn Cobb

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md

14 Informant Surie T Lawson
(Address) 218 A Gilmore St

15 Filed OCT 30 1922 ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18, 19 22, to Oct. 27, 19 22.

that I last saw him alive on Oct. 27, 19 22.

and that death occurred, on the date stated above, at 1.05 P. M.

The CAUSE OF DEATH* was as follows:

Thrombus - cardiac Syncope

CONTRIBUTORY (Secondary) Cerebral Apoplexy
(duration) yrs. mos. ds. 9

18. Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. Robert K. Eech, M. D.

, 19 (Address) 219 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Landon Park

DATE OF BURIAL

Oct 30 1922

20 UNDERTAKER

Robt T Turner Inc Broadway

ADDRESS 1421A

MARGIN RESERVED FOR BINDER
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 68723

D 68723

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1720 Rutland Ave 8 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Curran

(a) RESIDENCE NO. 1720 Rutland Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Curran

6 DATE OF BIRTH (month, day, and year) Nov 1867

7 AGE Years 71 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Annie Emmett (Address) 1720 Rutland Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 23, 1922, to Oct 28, 1922, that I last saw him alive on Oct 27, 1922, and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Gray, M. D. (Address) 1603 203 E. Enoch

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See back for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

UNDERTAKER John A. Turner Inc ADDRESS 1442 Broadway

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Anastasia Memmel
D 68724 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68724
90

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hospital 77* ST. *77* WARD)

2. FULL NAME *Anastasia Memmel*

(a) RESIDENCE NO. *2803. Overland* ST. *Over* WARD

(Usual place of abode)

Length of residence in city or town where death occurred

41 yrs.

— mos.

ds.

How long in U. S., if of foreign birth?

41 yrs.

— mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced HUSBAND or WIFE of *Michael Memmel*

6 DATE OF BIRTH (month, day, and year) *Dec. 25, 1848*

7 AGE Years *73* Months *10* Days *3* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)

10 NAME OF FATHER *Mr. Speiser*

11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town) *Not known* (State or country)

14 Informant *Mr. Michael Memmel* (Address) *1500 Holbrook*

15

Filed

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct. 28, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct. 8, 1922* to *Oct. 28, 1922* that I last saw him alive on *Oct. 28, 1922* and that death occurred, on the date stated above, at *9 20 p. m.* The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

CONTRIBUTORY (Secondary) *Cholera* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *Oct. 13/22*

Was there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *S. W. Krueger* M. D. (Address) *St. Joseph's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL

Holy Redeemer Cemetery *Oct. 27, 1922*

20 UNDERTAKER ADDRESS

Henry Horck *1301 E. 11th*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68725
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital. St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Charles A. Luebeck.

(Residence in Baltimore: No. 2826 Harlem Ave. St.; yrs. 42 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Married.
(Write the word.)

6-DATE OF BIRTH, July 22nd. 1850
(Month) (Day) (Year)

7-AGE, 72 yrs. 3 mos. 5 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Retired
(b) General nature of industry, business, or establishment in which employed (or employer), Watchman.

9-BIRTHPLACE, (State or Country), Germany.

10-NAME OF FATHER, John Luebeck.

11-BIRTHPLACE OF FATHER, (State or Country), Germany.

12-MAIDEN NAME OF MOTHER, Do not know.

13-BIRTHPLACE OF MOTHER, (State or Country), Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Julia Luebeck. (wife.)

(Address), 2826 Harlem Ave.

15-

Filed

OCT 30 1922

ROBERT R. KRAUTER
Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 27th. 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull. Intracranial hemorrhage.
Accidentally struck by car #5100 of U. Ry. & E. Co. (Duration) ... yrs. ... mos. ... 2 ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.
(Signed) Otto M. Reinhardt M. D.
(Coroner)
Oct 29 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Accident, Edmondson Ave. & Western
Former or usual residence Cemetery gate. 10/25/22.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

St. Matthew Cemetery Oct. 30, 1922

20-UNDERTAKER, ADDRESS

Henry Webb Linn 1301 E. Eager St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68726

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1182 Sargeant ST., 21 WARD)

2-FULL NAME

Alice Mary Freese

(a) RESIDENCE NO.

1182 Sargeant

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

38 yrs. 0 mos. 10 ds.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofWilliam H. Freese

6 DATE OF BIRTH (month, day, and year)

Oct 17, 1884

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.38010

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

At Home

9 BIRTHPLACE (city or town) (State or country)

Bald. Md.

10 NAME OF FATHER

Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Don't Know

12 MAIDEN NAME OF MOTHER

Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Don't Know

14

Informant
(Address)Wm. H. Freese
1182 Sargeant St.

15

Filing
OCT 30 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

May 1, 1922, to Oct 27, 1922.that I last saw him alive on Oct 27, 1922.and that death occurred, on the date stated above, at 3:20 p. m.

The CAUSE OF DEATH* was as follows:

Uremic Poison

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. 14

ds.

(duration)

yrs.

mos. 28

ds.

18 Where was disease contracted

if not at place of death?

Do not know

Did an operation precede death?

No Date of —

Was there an autopsy?

—

What test confirmed diagnosis?

Urine Test.

(Signed)

E. Miles Stuckey M. D.

19

(Address)

2129 W. 7th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Wm. Oluch Ave. Oct. 30 1922

20 UNDERTAKER

ADDRESS

Wm. Oluch Ave. 801 W. Bayette

MARGIN RESERVED FOR BINDER
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68727

CERTIFICATE OF DEATH.

129 D 68727

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1174 Nanticoke ST., 21 WARD)

2. FULL NAME

(a) RESIDENCE NO. 1174 Nanticoke ST., 21 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 10 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of William Boyce

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1848

7 AGE Years 73 Months 10 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) Don't know (State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Don't know (State or country)

14 Informant Kate Pfeiffer (Address) 1174 Nanticoke St.

15 Filed Oct 30 1922 Registrar Robert R. ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1922

17 I HEREBY CERTIFY, that I attended deceased from June 1 - 1922 to Oct 28 1922. That I last saw him alive on Oct 28 1922.

and that death occurred, on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac Aschemia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. Ch Int Nepl

(duration) yrs. mos. ds. 3

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalyses

(Signed) John Schwenker M. D.

, 19 (Address) 1176 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Oct 31 1922

20 UNDERTAKER John ... ADDRESS ...

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-MAT 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68728

CERTIFICATE OF DEATH.

129 D 68728

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 26 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Ryan

(a) RESIDENCE No. Unknown
(Usual place of abode)

ST. _____ WARD _____
(If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
69 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records
(Address)

15 OCT 30 1922 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 1922

17 I HEREBY CERTIFY, That I attended deceased from July 15 1920, to October 28 1922, that I last saw him alive on October 27 1922, and that death occurred, on the date stated above, at 5:25 A.M.
The CAUSE OF DEATH* was as follows:

Chronic nephritis
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) _____
(duration) _____ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? _____
(Signed) Chas. M. Neill M. D.

10/28/22 Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Johns Cathedral Cem DATE OF BURIAL 10/30/1922

George F. Ruth ADDRESS 1735 Harford Ave
UNDER-TAKER

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68729

CERTIFICATE OF DEATH.

129 D 68729

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 805 Homestead St. ST. 9 WARD 9

2-FULL NAME

(a) RESIDENCE No. 805 Homestead St. ST. 9 WARD 9

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Druey

6 DATE OF BIRTH March 4, 1879 7 AGE Years 73 Months 7 Days 23 8 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 27, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922, to Oct 27, 1922, that I last saw him alive on Oct 27, 1922, and that death occurred, on the date stated above, at 7:15 P. M. The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

CONTRIBUTORY (Secondary) Anterior Infarct (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. W. H. M. D.

(Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Cemetery

10/30/1922

20 UNDERTAKER

ADDRESS

George J. Ruth

135 Harford Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68730

CERTIFICATE OF DEATH.

38 D 68730

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 W. Franklin ST. 18 WARD)

2. FULL NAME Mary Brewer

(a) RESIDENCE NO. 803 W. Franklin ST. WARD

(Usual place of abode) Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX H. 4 COLOR OR RACE Negro 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND or (or) WIFE of James Brewer

6 DATE OF BIRTH (month, day, and year) Jan 24, 1880

7 AGE 32? Years 3 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Daniel Gled

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country) H. W. Co.

12 MAIDEN NAME OF MOTHER Martha Fisher

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Daughter (Address) 803 W. Franklin H.

15 Filed OCT 30 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 20, 1922, to Oct 28, 1922, that I last saw her alive on Oct 28, 1922, and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis, uremia, with myocardial collapse

(duration) yrs. mos. ds. CONTRIBUTORY Primarily Syphilis. History (Secondary) years (duration) yrs. mos. ds.

18 Where was disease contracted Unknown if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical (Signed) Victor Richards M. D. (Address) 220 Equitoke Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

D 68731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68731

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Ashland Ave ST.: 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 1804 Ashland Ave ST.: 7 WARD.

(Usual place of abode) (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 25 1912 7 AGE Years Months Days 4 If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not any (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant (Address)

15

Filer

ROBERT R. KRAUSE Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-29 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1922, to Oct 29, 1922, that I last saw her alive on Oct 28, 1922, and that death occurred, on the date stated above, at 6 a.m.
The CAUSE OF DEATH* was as follows:

Premature birth

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. E. Thomas M. D.
10-29-22 Address 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Laurel Cemetery, Oct 30 1922
Joseph J. H. KetchumMARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68732 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68732

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1140 Vincent ST. 16 WARD)
2-FULL NAME Mrs. Laura Morris
(a) RESIDENCE. NO. 1140 N. Vincent ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.	4 COLOR OR RACE Colored	5 Single, Married, Widowed, or Divorced (write the word) Married
5a If married, widowed, or divorced HUSBAND of George H. Morris (or) WIFE of		
6 DATE OF BIRTH (month, day, and year) Aug. 17. 1867		
7 AGE Years 55 Months 2 Days 10	If LESS than 1 day, hrs. or min.	
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Landress (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer		
9 BIRTHPLACE (city or town) (State or country) Md		
10 NAME OF FATHER Not known		
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md		
12 MAIDEN NAME OF MOTHER Not known		
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md		

14 Informant Mary Mallory 926 Parish St.
15 OCT 30 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18th 1922, to Oct. 27th 1922, that I last saw her alive on Oct. 27th 1922, and that death occurred, on the date stated above, at 5 09^{PM} m.
The CAUSE OF DEATH was as follows:
Acute Gastritis
(duration) yrs. mos. 9 ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptomatology
(Signed) Asst. Dr. Jell M. D.
, 19 (Address) 1224 N. Belmont St.
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL
20 UNDERTAKER James A. Davis ADDRESS 303 Greenway

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Rk.

D 68733

161-001
REGISTERED

REGISTERED NO

CITY OF BALTIMORE: (No.

ST. ... WARD

(a) RESIDENCE NO. 1401 Baniadi

ST., WARD

WARD

(Usual place of abode)

(11 non-resident give city or town and State)

Length of residence in city or town where death occurred

YES

MOS

ds

How long in U. S., if of foreign birth?

FIVE

TOWN

1c)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1922

17 I HEREBY CERTIFY, That I attended deceased from
Oct 25, 1922, to Oct 26, 1922.

that I last saw him alive on Oct. 25, 1922

and that death occurred, on the date stated above, at 4³⁰ A. m.

The CAUSE OF DEATH* was as follows:

USE OF DEATH* was as follows:

Premature Birth (251)

(duration) yrs. mos. 1 da.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. mos. ds.

18 Where was disease contracted

Did an operation precede death? no Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Excisional biopsy of the*

(Signed) James H. Kline Glass, M. D.

, 19 (Address) 1401 Division St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL.

20 UNDERTAKER

ADDRESS

067301922

ROBERT R. KRAUTER.

Registrar

~~Serial Permit Check~~

NAME *Martin F. Hayes* ADDRESS *1829 W. North*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 68734 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68734
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 18 WARD)

2-FULL NAME Pauline Johnson

(a) RESIDENCE No. 108 E. Schroeder St.

ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Unknown Years Months Days If LESS than 1 day, hrs or min. 50 ? -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Eastern Shore,
(State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 ROBERT R. KRAUTER,

Filed OCT 30 1922

Burial Permit Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 19 22

17

I HEREBY CERTIFY, That I attended deceased from October 25, 19 22. to October 26, 19 22.
that I last saw her alive on October 26, 19 22.
and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. 2

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clyde M. Munn, M. D.

10/27/22 Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

not at home Oct 30 19 22

20 UNDERTAKER

ADDRESS 1140

Brown & Ireland

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68735 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 636 Sarah Ann St., 4 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Murray

(Residence in Baltimore: No. 636 Sarah Ann St., yrs. 25 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female
4-COLOR OR RACE Colored
5-Single, Married, Widowed, or Divorced, (Write the word.) Mdm

6-DATE OF BIRTH. Not known
(Month) (Day) (Year)

7-AGE 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Mail
(b) General nature of industry, business, or establishment in which employed (or employer). 070

9-BIRTHPLACE. (State or Country). Md

PARENTS:
10-NAME OF FATHER. Jas Dorsey
11-BIRTHPLACE OF FATHER. (State or Country). Md
12-MAIDEN NAME OF MOTHER. Sarah Buckner
13-BIRTHPLACE OF MOTHER. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William McConkey

(Address) 636 Sarah Ann St

15- Filed OCT 30 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart
(Duration) yrs. Not known ds.

CONTRIBUTORY (Secondary) Not known
(Duration) yrs. mos. ds.

(Signed) N. J. Gorman M. D. (Coroner)
1030 1022 (Address) 117 N. Saratoga St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

M. J. Arthur Oct 31 1922

20-UNDERTAKER, ADDRESS

Charles A. Wright 636 1/2 W. Ave.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D

68736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED No. C

57 D 68736

PLACE OF DEATH

CITY OF BALTIMORE (No.

FULL NAME

(Residence in Baltimore: No.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX male 4-COLOR OR RACE white 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) widowed

6-DATE OF BIRTH June 5th, 1865 (Month) (Day) (Year)

7-AGE 57 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Insurance Broker (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER Joseph Smith

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jerome Politzer

(Address) 2124 Brookfield Ave

15. OCT 30 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 10 29, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-20, 1918, to 10-29, 1922, that I saw him alive on 10-29, 1922, and that death occurred, on the date stated above, at 1 P. m. The CAUSE OF DEATH* was as follows:

Acute indigestion

Contributory (SECONDARY) Dilated right Heart

(Signed) Arthur G. Barrett M. D.

10-29, 1922 (Address) 2000 E. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Balto Hebron

20-UNDERTAKER J. Ahrens & Co

ADDRESS

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*,

meninges, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, *Haemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyæmia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicæmia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*,

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides*, *Homicides*, *Abortions (if induced)*, whether death is directly or indirectly due to the same.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-0-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

68737

CERTIFICATE OF DEATH

129

D 68737

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: NO.

ST.:

WARD)

2-FULL NAME

Julius Kasanowitz

116 North Hollinsworth

(a) RESIDENCE. NO.

Collington ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs.

mos.

ds.

How long in U. S., if of foreign birth? 22 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Barney Kasanowitz

6 DATE OF BIRTH (month, day, and year)

1869

7 AGE

Years

Months

Days

LESS than 1 day, hrs. or min.

53

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Benjamin Greenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E. Baltimore

15

Filed

19

OCT 30 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 30

19

17

I HEREBY CERTIFY, That I attended deceased from

Oct 25

19

22

to

Oct 30

19

22

that I last saw him alive on

Oct 30

19

and that death occurred, on the date stated above, at

12:30 m.

The CAUSE OF DEATH* was as follows:

chronic nephritis
High Blood Pressure

(duration) 2 yrs.

mos.

ds.

CONTRIBUTORY

(Secondary)

Bronchopneumonia

(duration)

yrs.

mos.

2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of

no

Was there an autopsy?

no

What test confirmed diagnosis?

Urinary & Blood Exam

(Signed)

A. Miller, M. D.

10/30/1922 (Address)

Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Hebrew Mt Carmel

10/30 1922

20 UNDERTAKER

ADDRESS

Jack Lewis 1439 E. Baltimore

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001 D 68738

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 721 W. Baltimore

ST. 4 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME

George Frickin

(Residence in Baltimore: No.

CITY 721 W. Baltimore

St. 4 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)

widower

6 DATE OF BIRTH

Oct. 29, 1845

7 AGE

77

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

furnier

9 BIRTHPLACE (State or country)

Russia

10 NAME OF FATHER

Meyer Frickin

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Etter Frickin

13 BIRTHPLACE OF MOTHER (State or country)

Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Meyer Frickin (son)

(Address)

721 W. Balt St

15

Filed

OCT 30 1922

ROBERT R. KRAUTER,

Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 29, 1922

17. I HEREBY CERTIFY. That I attended deceased from

Oct 15, 1922, to, Oct. 29, 1922.

that I saw him alive on Oct. 29, 1922.

and that death occurred, on the date stated above, at 11¹⁵ p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

Contributory (SECONDARY)

Arteriosclerosis & Old age

(Duration) yrs. mos. ds.

(Signed) David J. Knecht M. D.

Oct 30, 1922 (Address) 3410 Woodmont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Rosedale

DATE OF BURIAL

10/30, 1922

20 UNDERTAKER

John J. Lewis 1439 E. Balto

ADDRESS

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68739

CERTIFICATE OF DEATH.

129 D 68739

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *11024-24* ST. *12* WARD)

2-FULL NAME

(c) RESIDENCE NO. *11024-24*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *None*

6 DATE OF BIRTH (month, day, and year) *Nov 16 1860*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *61 11 12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer) *Retired*

(c) Name of employer *Schoolteacher*

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md*

10 NAME OF FATHER *James H. Sumwalt*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*

12 MAIDEN NAME OF MOTHER *Mary Lee*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md*

14

Informant (Address) *601 E. Baltimore*

15

Filed

19

Registar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 28 19 21*

17

I HEREBY CERTIFY, That I attended deceased from *June 15*, 19*20*, to *Oct 28*, 19*21*, that I last saw her alive on *Oct 28*, 19*21*.

and that death occurred, on the date stated above, at *1:45 P* m.

The CAUSE OF DEATH* was as follows:

Acute diffuse nephritis

(duration) yrs. *3* mos. *11* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. *1* mos. *1* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Frederick M. Smith, M. D.*

, 19 (Address) *4420 Maryland Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD
 CERTIFICATE OF DEATH
 [Approved by U. S. Census and American Public Health Assoc.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
 BY PHYSICIAN.

Dr Geo W Little
2435 - Md. Ave
Ch. Nephritis

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68740 *Ella Williams* HEALTH DEPARTMENT—CITY OF BALTIMORE D 68740
CERTIFICATE OF DEATH X 113
1-PLACE OF DEATH
City of BALTIMORE: (No. *Johns Hopkins Hosp.* St. *7* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Ella Williams*
(Residence in Baltimore: No. *Roseville* St.; yrs. *2* mos. *2* ds.)

PERSONAL AND STATISTICAL PARTICULARS.
3-SEX *Female* 4-COLOR OR RACE *Black* 5-Single, Married, Widowed, or Divorced. (Write the word.)
6-DATE OF BIRTH *April 19* 1922 (Month) (Day) (Year)
7-AGE *6* yrs. *10* mos. *10* ds. If LESS than 1 day, hrs. or min.
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *chess*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), *Md.*
PARENTS:
10-NAME OF FATHER, *C. Williams*
11-BIRTHPLACE OF FATHER, (State or Country), *Loralee Md*
12-MAIDEN NAME OF MOTHER, *Evelyn Johnson*
13-BIRTHPLACE OF MOTHER, (State or Country), *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Ann Williams (Mother)*
(Address) *Roseville Md.*

15- *OCT 30 1922*
Filed *1922* ROBERT R. KRAUTER, Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.
16-DATE OF DEATH, *Oct 29* 1922 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* and that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.
The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
PM at Hospital (Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Signed) *John P. Baker* M. D. (Coroner.)
10-30 1922 (Address) *528 E North*
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence
19-PLACE OF BURIAL OR REMOVAL, *Loralee Md* DATE OF BURIAL, *Oct. 30 1922*
20-UNDERTAKER, *Daniel T. Hemphill* ADDRESS *378 W. Biddle St*

Remarks

Diarrhoea & Enteritis

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyæmia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicæmia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68741

D 68741

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Woodall ST., 24 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

43 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

Married

5a If married, widowed, or divorced (or) WIFE of

HUSBAND of Howard E. McElwee

6 DATE OF BIRTH (month, day, and year)

Jan 2 - 79

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

43

9

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Fred. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Barbara

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Howard E. McElwee 1416 Woodall St.

15

Filed

OCT 30 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 27 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct 27th, 1922, to Oct 27th, 1922.

that I last saw her alive on Oct 27th, 1922,

and that death occurred, on the date stated above, at 8:50 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration)

Unknown

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Nervous & acute dilatation of heart

18 Where was disease contracted if not at place of death?

at place of death

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Findings

(Signed)

Harry Heibel, M. D.

10/29, 1922 (Address)

1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

Philp Henry

ADDRESS

2016 Orleans

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MNT 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68742

CERTIFICATE OF DEATH.

47 D 68742

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hosp ST. 76 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years
72

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

ROBERT R. KRAVITZ

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-28 1922

17

I HEREBY CERTIFY, That I attended deceased from

7-15 1922 to 10-28 1922.

that I last saw her alive on 10-28 1922.

and that death occurred, on the date stated above, at 10:25 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast (rt) with metastases to lymphatics of right arm, chest & back

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of about 7 mo. ago

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. Richardson, M. D.

19 (Address) Bay View Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68743

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

D 68743

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Gay & Federal Sts.* ST.

WARD)

2-FULL NAME

Pleasant H. Bull

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

21 Kellb Avenue

St.; (yrs., *2*) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*

6-DATE OF BIRTH,

Nov. 2, 1879
(Month) (Day) (Year)

7-AGE,

44

11 yrs. *11* mos. *10* ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Engineer

9-BIRTHPLACE, (State or Country),

Balto. Co.

10-NAME OF FATHER,

Emanuel Bull

11-BIRTHPLACE OF FATHER (State or Country),

Balto Co.

12-MAIDEN NAME OF MOTHER

Martha Jane Tyson

13-BIRTHPLACE OF MOTHER (State or Country),

Balto. Co.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs. Elizabeth Bull

(Address)

21 Kellb Ave

OCT 30 1922

ROBERT R. KRAUTER,

Filed

191

BURIAL FORM

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 28, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, au-

inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed heart left crushed skull above left ear. Struck car passed over chest. (inquest report to be held Oct 30 at 8:30 PM.) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J. H. Haller
(Coroner.)

Oct 30, 1922 (Address) *505 E North Ave*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place In the of death yrs. mos. ds. State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Weisburg Church

DATE OF BURIAL,

Oct. 31, 1922

20-UNDERTAKER

E. LeRoy Stiffler

ADDRESS

125 E. North

D 68744 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68744

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 1st Ave 76 ST. WARD)

2-FULL NAME

Louise Reiter

(a) RESIDENCE NO.

3501 1st Ave 26 ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 27 1922

7 AGE

Years

Months

Days

If LESS than 1 day, 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

William Adam Reiter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md

12 MAIDEN NAME OF MOTHER

Anna Heintz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant

(Address)

Mrs Anna Reiter 3501 1st Ave

15

Filed

19

ROBERT R. KRAUTER

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 27 1922 to Oct 27 1922

that I last saw her alive on Oct 27 1922

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

6 Month Foetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tidlow M. D.

Oct 27 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Johns Hopkins Embury Dept Oct 27 1922

20 UNDERTAKER

ADDRESS

H. B. Tidlow

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68745

CERTIFICATE OF DEATH.

117 D 68745

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Wolfe Hospital ST. 9 WARD)

2-FULL NAME

Edward Novek

(a) RESIDENCE NO.

529 E. 27th St.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m

4 COLOR OR RACE

w

5 Single, Married, Widowed, or Divorced, (write the word)

(married)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Betha Frank

6 DATE OF BIRTH (month, day, and year)

June 15-1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

30

4

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

163

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt -

10 NAME OF FATHER

Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balt -

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balt -

14 Informant (Address)

Wm. J. Drury
508 E. 27th St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

10-1-1919

17

I HEREBY CERTIFY, That I attended deceased from

10-1-1919, 19, to 10-2-1919, 19,

that I last saw him alive on 10-29-1919, 19,

and that death occurred, on the date stated above, at 5:55 p. m.

The CAUSE OF DEATH* was as follows:

Streptococcus pneumoniae

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 10-14-19

Was there an autopsy? no

What test confirmed diagnosis? General & Clinical

(Signed) Wm. J. Drury M. D.

, 19 (Address) Wolfe Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Wood Lane

DATE OF BURIAL

Nov 1 1919

20 UNDERTAKER

Wm. Cook

ADDRESS

508 E. 27th St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68746

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 2317 11 (Elvin) ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1974

I HEREBY CERTIFY, That attended deceased from
July, 1922, to Oct 28, 1922
I last saw h alive on Oct 28, 1922

6 DATE OF BIRTH (month, day, and year) 7, 7, 3

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... *at Home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER Arthur M. Caffery

II BIRTHPLACE OF FATHER (city or town).....

12 MAIDEN NAME OF MOTHER *McDonald* *Y* *0*

13 BIRTHPLACE OF MOTHER (city and state)

(State or country) Ireland

14 Informant B. R. Fowler
(Address) 5317 73rd Ave

15 CT 201922 ROBERT B KRAUTER

and that death occurred, on the date stated above, at 445 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombus

(duration) yrs. 2 mos ds

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.

Was there an autopsy? Yes

What test confirmed diagnosis? *48*

(Signed) *David M. Estman Jr.* M.D.

10/29 1922 (Address) 1505 Edmundson

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Love
You down (ark)

10/31/2

20 UNDERTAKER

ADDRESS _____

Excision of the

Case # No?

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68747

CERTIFICATE OF DEATH.

179 D 68747

1-PLACE OF DEATH

CITY OF BALTIMORE (NO

2-FULL NAME

(a) RESIDENCE, NO

(Usual place of abode)

Length of residence in city or town where death occurred

45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

45 yrs.

mos.

ds.

WARD.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (Write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1922 to Oct 29, 1922

that I last saw him alive on Oct 29, 1922

and that death occurred, on the date stated above, at one a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration)

1 yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

John H. Arvey

M. D.

, 19

(Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

William Cook

5028 North

Mr Arvey 1603 N. Broadway

MARGIN RESERVED FOR PRINTING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68748

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44/ D 68748

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1518 Canswell ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Burke Seinsz

(a) RESIDENCE No. 1518 Canswell
(Usual place of abode)

ST., _____ WARD _____
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Seinsz

6 DATE OF BIRTH (month, day, and year) May 3, 1848

7 AGE Years 77 Months 5 Days 25 If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Peach Bottom, York Co., Pa.
(State or country)

10 NAME OF FATHER Ruben Hutton

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Evelyn Burke

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Pennsylvania

14 Informant Mr. Jodie Hall
(Address)

15 Filed _____, 19 _____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1922

17 I HEREBY CERTIFY, That I attended deceased from October 22, 1922, to October 28, 1922.

that I last saw him alive on October 28, 1922.

and that death occurred, on the date stated above, at 12:45 p.m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Allen C. Beatham, M. D.

10-28-1922 (Address) 3139 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Baltimore

DATE OF BURIAL

Oct 30 1922

20 UNDERTAKER

ADDRESS

Wendroff 505 E North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68749

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 1215 W. Larrale ST. 16 WARD)

2-FULL NAME

Eliza V. Billmire (Billmire)

(a) RESIDENCE. NO.

1215 W Larrale ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm H Billmire

6 DATE OF BIRTH (month, day, and year)

Apr 14 1838

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Benjamin West

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Dout Knorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Dout Knorr

14

Informant (Address)

Milton Billmire 1215 W Larrale St

15

Filed

19

ROBERT H. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct 7 19 22 to Oct 28 19 22

that I last saw her alive on Oct 28 19 22

and that death occurred, on the date stated above, at 11.15 A.M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis and Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm H. London M. D.

, 19 (Address) 750 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Greenmount Oct 30 19 22

20 UNDERTAKER

ADDRESS

Wm H. London 502 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68750

CERTIFICATE OF DEATH.

129 D 68750

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

516 N. Drucker St.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

John Kaiser

(a) RESIDENCE. NO.

516 N. Drucker St.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds.

How long in U. S., if of foreign birth? 54 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Elizabeth Kaiser

6 DATE OF BIRTH (month, day, and year) Sept. 2, 1846

7 AGE 76 Years 1 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John M. Kaiser (Address) 516 N. Drucker St.

15 Filed OCT 30 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1922

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1922, to Oct 29, 1922, that I last saw him alive on Oct 28, 1922, and that death occurred, on the date stated above, at 10 A. m. The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

CONTRIBUTORY (duration) 2 yrs. mos. ds. Chronic Rheumatism, Arteriosclerosis (Secondary) (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Albert T. Lerman, M. D. 10/29, 1922 (Address) 718 N. Patterson St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart.

DATE OF BURIAL

Oct. 31 1922

20 UNDERTAKER

William Cook.

ADDRESS

502 E. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68751

D 68751

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 853 Harlem Ave St.; 17 WARD)

REGISTERED NO. C

2-FULL NAME

(Residence in Baltimore: No. 853 Harlem Ave St.; 17 yrs., 12 mos., 28 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

2-SEX, Male 4-COLOR OR RACE, White 5-SINGLE, Married, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)6-DATE OF BIRTH, April 7, 1878 (Month) (Day) (Year)7-AGE, 44 yrs., 6 mos., 21 ds. If LESS than 1 day, hrs. or min.8-OCCUPATION: (a) Trade, profession, or particular kind of work, clerk (b) General nature of industry, business, or establishment in which employed (or employer), 0099-BIRTHPLACE, (State or Country), Penn10-NAME OF FATHER, John J. Moltz11-BIRTHPLACE OF FATHER (State or Country), Ind12-MAIDEN NAME OF MOTHER, Kate B. Courzeau13-BIRTHPLACE OF MOTHER (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Kate B. Moltz(Address), 12610 Allen St. Baltimore

15-ROBERT R. KRAUTER, Registrar

Filed, Oct 30 1922 191

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28, 1922 (Month) (Day) (Year)17-I HEREBY CERTIFY, That I attended deceased from Sept 9 1922, to Oct 28 1922, that I saw him alive on Oct 28 1922, and that death occurred, on the date stated above, at 2:30 a. m. The CAUSE OF DEATH* was as follows:Respiratory infection
prob. Pertussis
(Duration) yrs. mos. ds.CONTRIBUTORY Broncho pneumonia
(Secondary) (Duration) yrs. mos. ds.(Signed), Wm. L. Todd M. D.
Oct 28, 1922 (Address), 725 N. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park DATE OF BURIAL, Oct 30, 192220-UNDERTAKER, John C. Mitchell ADDRESS, 1200 N. FayetteWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68752

CERTIFICATE OF DEATH.

D 68752

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2132 Cambridge ST., 2 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1922

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1922, to Oct 28, 1922.

that I last saw him alive on Oct 27, 1922.

and that death occurred, on the date stated above, at 10:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

12Y68753 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68753
CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3 WARD)

2-FULL NAME

Libera Guarino

(a) RESIDENCE NO.

1514 Gough St. City

(Usual place of abode)

Length of residence in city or town where death occurred

Life mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced

HUSBAND of

Anthony Guarino (mother of offspring)

6 DATE OF BIRTH (month, day, and year)

June 1, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Lewis Guarino

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Italy

12 MAIDEN NAME OF MOTHER

Anthony Guarino

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Italy

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed 1501922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 28 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 8, 1922, to Oct 28, 1922.

that I last saw her alive on Oct 28, 1922.

and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St Vincent

DATE OF BURIAL

Oct 30 1922

20 UNDERTAKER

Wendell Dwyer 370 M

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this form should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68754

CERTIFICATE OF DEATH.

91-002

D 68754

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4207 Frederick Ave. ST. 20 WARD)

2-FULL NAME Lillian I. Knell

(a) RESIDENCE No. 4207 Frederick Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. William A. Knell

6 DATE OF BIRTH (month, day, and year)

7 AGE 37 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER William F. McKewen

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza McKewen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Dr. William A. Knell (Address) 4207 Frederick Ave.

15 Filed 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 19 22, to Oct 29, 19 22,

that I last saw her alive on Oct 29, 19 22,

and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(duration) yrs. mos. 1/2 hr

CONTRIBUTORY (Secondary) Coronary Arterial Sclerosis

(duration) yrs. mos. 10 yrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones, M. D.

Address Dr. Howard W. Jones

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

New Cathedral Cemetery? Oct 31 19 22

20 UNDERTAKER ADDRESS

Joseph B. Cook 1003 1/2 Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68755

CERTIFICATE OF DEATH.

D 68755

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2612 Oswego Ave. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emma A. Slade

(a) RESIDENCE NO.

2612 Oswego Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Thomas T. Slade

6 DATE OF BIRTH (month, day, and year) June 29th 1857

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
65 3 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Md.

10 NAME OF FATHER Mr. Shirley

11 BIRTHPLACE OF FATHER (city or town) U. S.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs. Blanche Michael
(Address) 2612 Oswego Ave.

15 Filed 1922, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 27th 19 22

17

I HEREBY CERTIFY, That I attended deceased from September 1st, 19 22, to Oct. 27th, 19 22, that I last saw her alive on Oct. 27th, 19 22,

and that death occurred, on the date stated above, at 10.10 P. M.

The CAUSE OF DEATH* was as follows:

Atherosclerosis
Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unarmed

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinary.

(Signed) William F. Steelman, M. D.

10/28 28 Address 1227 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

Wood Ridge Cemetery Oct 30th 19 22

20 UNDERTAKER ADDRESS

Joseph B. Cook 1003 N. Baltimore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68756

CERTIFICATE OF DEATH.

Registered D 68756

1-PLACE OF DEATH

City of BALTIMORE: (No. *en Road to Hospital* St. *6* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

John R. King
(Residence in Baltimore: No. *420 N. Bittel* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Colored* 5-Single, Married, Widowed, or Divorced, *Married*
(Write the word.)

6-DATE OF BIRTH, *Month* *Day* *Year*
Don't know

7-AGE, *20* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Chauffeur*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Beth Md*

PARENTS.

10-NAME OF FATHER, *C. King*

11-BIRTHPLACE OF FATHER, (State or Country), *Va*

12-MAIDEN NAME OF MOTHER, *Mary King*

13-BIRTHPLACE OF MOTHER, (State or Country), *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Elmer King*

(Address) *420 N. Bittel St*

15.

Filed

ROBERT R. KRAUTER,

Bureau of Vital Records

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct* *26*, 19*22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Crushed chest & abdomen

CONTRIBUTORY *Struck by auto freight* (Duration) *2* yrs. mos. ds.
(Secondary) *2* yrs. mos. ds.

(Signed) *W. B. Jones* M. D.
(Coroner.)

Oct 30 19*22* (Address) *117 N. Saratoga St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, *Evergreen*

DATE OF BURIAL, *Oct 30*, 19*22*

20-UNDERTAKER, *W. B. Jones*

ADDRESS *108 N. Montgomery St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D 68757

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

3 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 9-1897

7 AGE 25 Years Months Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 26 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 22 1922 to Oct 26 1922 that I last saw him alive on Oct 26 1922 and that death occurred, on the date stated above, at 120 P. M.

The CAUSE OF DEATH* was as follows: Osteomyelitis lower jaw

CONTRIBUTORY (Secondary)

(duration) yrs. 2 1/2 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9-8-22/4-29-22

Was there an autopsy?

What test confirmed diagnosis? Widal & Ber

(Signed) J. J. S. M.D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John W. Henderson

1501

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Probably a Sarcoma of
Lower Jaw.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68758

CERTIFICATE OF DEATH.

D 68758

1-PLACE OF DEATH

Hotel Belorden

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST. 11

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Angus Hailes McLean

(a) RESIDENCE. NO.

Hotel Baltimore New York

ST.

WARD.

(Usual place of abode)

New York

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

42

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Bertrude P. McLean

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1867 Apr 10

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

6

14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Sugar Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Owner

9 BIRTHPLACE (city or town) (State or country)

Hallettsville Texas

10 NAME OF FATHER

Hector McLean

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Scotland

12 MAIDEN NAME OF MOTHER

Sarah Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Alabama

14

Informant (Address)

Mrs L. P. Bosworth
Garden City, Maryland

15

Filed

OCT 30 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 29, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 9, 1922, to Oct 29, 1922,

that I last saw him alive on Oct 29, 1922,

and that death occurred, on the date stated above, at 3:24 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
and acute dilatation of heart
(Myocardial Infarction) duration 2 mos. 20 ds.

CONTRIBUTORY (Secondary)

Coronary Embolus

18 Where was disease contracted if not at place of death?

Hotel Belorden

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & history

(Signed) J. A. Lutzsch, M. D.

, 19 (Address) 1025 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Nashville, Tenn

DATE OF BURIAL

Oct 30 1922

20 UNDERTAKER

Henry J. Zuker Son

ADDRESS

McCuish
614 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68759

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE, NO.

501 E. 28th

ST.;

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Irene A. Phillips

(Residence in Baltimore: No.

501 E. 28th st.

St.; X yrs., X mos., X ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR SEPARATED. *Single*
(Write the word.)

6-DATE OF BIRTH, *Oct. 29, 1922*
(Month) (Day) (Year)

7-AGE, yrs. mos. ds. If LESS than 1 day, hrs. or 5 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *None*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balto. Md.*

10-NAME OF FATHER, *Wm. J. Phillips*

11-BIRTHPLACE OF FATHER (State or Country), *Balto. Md.*

12-MAIDEN NAME OF MOTHER, *Irene A. Byers*

13-BIRTHPLACE OF MOTHER (State or Country), *Balto. Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- *OCT 30 1922* *ROBERT R. KRAUTER,*
Filed....., 191.....
Burial Permit *19626*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct. 29, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct. 29, 1922*, to *Oct. 29, 1922*, that I saw him alive on *Oct. 29, 1922*, and that death occurred, on the date stated above, at *7:40 P.M.*
The CAUSE OF DEATH* was as follows:
Premature Birth.

(Duration)..... yrs. mos. ds.
CONTRIBUTORY (Secondary) *Unknown*

(Signed) *William J. Phillips* M. D.
Oct. 30, 1922 (Address) *1415 Cedar St. Balto.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,, 191...

20-UNDERTAKER ADDRESS.....

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68760

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *814 S. Robinson St.* ST. *1* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. *814 S. Robinson St.* ST. *1* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *47* yrs. mos. ds. How long in U. S., if of foreign birth? *47* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married.*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Chunigunda Baier*6 DATE OF BIRTH (month, day, and year) *Mar. 13 - 1855*7 AGE Years *66* Months *10* Days *15* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Laborer.*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany.*10 NAME OF FATHER *Frank Baier*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany.*12 MAIDEN NAME OF MOTHER *Barbara Eydloth.*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany.*14 Informant *Chunigunda Baier* (Address) *814 S. Robinson St.*15 Filed *Robert F. Barrison* 19 *1922*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 28 1922*17 I HEREBY CERTIFY, That I attended deceased from *Oct 1*, 19*21*, to *Oct 28*, 19*22*, that I last saw him alive on *Oct 27*, 19*22*, and that death occurred, on the date stated above, at *10.50 A.* m.

The CAUSE OF DEATH* was as follows:

*Chronic interstitial Nephritis*CONTRIBUTORY (Secondary) *Chronic Inguenidite* (duration) *1* yrs. mos. ds.(duration) *6* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Observation*(Signed) *STB Titlow* M. D.Address *315 S. Highland Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Cem.

DATE OF BURIAL

Oct. 31 1922

20 UNDERTAKER

Lilly & Zeiler

ADDRESS

403 S. Wolfest.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68761

CERTIFICATE OF DEATH.

D 68761

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3428 Eastern Ave. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha E. Tuckolka(a) RESIDENCE NO. 3428 Eastern Ave ST. 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11th 19047 AGE Years 18 Months 6 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)10 NAME OF FATHER Gustav Tuckolka11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Barbara Baumann13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)14 Informant Gustav Tuckolka (Address) 3428 Eastern Ave.15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29th 192217 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 1922, to Oct. 29, 1922.that I last saw her alive on Oct. 29, 1922.and that death occurred, on the date stated above, at 2:20 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - Broncho

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? None Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank A. Glantz, M. D.Oct 30, 1922 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Cem.

20 UNDERTAKER

Gilly & Zeller

DATE OF BURIAL

Oct. 30 1922

ADDRESS

4008 Maple St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF CAUSE OF DEATH IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

D 68762

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68762

CERTIFICATE OF DEATH. X 49

1. PLACE OF DEATH

CITY OF BALTIMORE: (Name of Hospital, etc.) JOHNS HOPKINS HOSPITAL 7 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Dr. Mark Alexandria Gregg(a) RESIDENCE NO. Johns Hopkins Hospital ST. 7 WARD Utica, N.Y.

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if of foreign birth? 46 yrs. 1 mos. 21 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frances Gregg6 DATE OF BIRTH (month, day, and year) Sept-8-18467 AGE Years Months Days If LESS than 1 day, hrs. or min.
46 1 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist(b) General nature of industry, business, or establishment in which employed (or employer) Dentistry(c) Name of employer self9 BIRTHPLACE (city or town) Savannah,
(State or country) New York.10 NAME OF FATHER Alexandria Gregg.11 BIRTHPLACE OF FATHER (city or town) not known
(State or country) Ireland12 MAIDEN NAME OF MOTHER not known.13 BIRTHPLACE OF MOTHER (city or town) Utica,
(State or country) N.Y.14 Informant JOHNS HOPKINS HOSPITAL
(Address)15 Robert E. Harrison
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 192217 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1922 to Oct 30, 1922,
that I last saw him alive on Oct 30, 1922and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of larynx(duration) 2 yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? HomeDid an operation precede death? Yes Date of Oct 27 1922
gastrostomyWas there an autopsy? NoWhat test confirmed diagnosis? Operation(Signed) Emile Holman M. D., 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Clyde, N.Y.

DATE OF BURIAL

October-30-22

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

WILLIAM F. WOODEN, Successor108 W. NORTH AVE.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CT 301922

Permit Permit Clerk

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68763

HEALTH DEPARTMENT—CITY OF BALTIMORE

X74-001
D 68763

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Hotel Stafford* St. *W* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....*Samuel Ernest Swayze*

(Residence in Baltimore: No. *Hotel Stafford* St.; yrs. *0* mos. *1* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*

6-DATE OF BIRTH. *About 1876*
(Month) (Day) (Year)

7-AGE, *44* yrs. *0* mos. *0* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Attorney at Law*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). *New Jersey*

10-NAME OF FATHER, *Theo. J. Swayze*

11-BIRTHPLACE OF FATHER, (State or Country). *New Jersey*

12-MAIDEN NAME OF MOTHER, *Elizabeth Miller*

13-BIRTHPLACE OF MOTHER, (State or Country). *New Jersey*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *McBurr Edwards*

(Address) *Cherry Chase Md*

15-*Noted by Harrison,*

Filed, *1922* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 30* 19*22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

acute alcoholism
(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary).....

(Signed) *McBurr Edwards* M. D. (Coroner.)
192*2*. (Address) *1639 Perry*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence. *Washington Dc*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Washington Dc *Oct 30* 19*22*

20-UNDERTAKER, ADDRESS.

Stewart Mowbray *108 W. North Ave*
W F Mordue

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D 68764

HEALTH DEPARTMENT—CITY OF BALTIMORE

68764

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 Hawthorne Rd ST., 27 WARD)

2-FULL NAME

David Williams Laws

(a) RESIDENCE NO.

118 Hawthorne Rd ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? 69 yrs. 1 mos. 27 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Resident

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Katherine F. Laws

6 DATE OF BIRTH (month, day, and year)

Sept-3-1853

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

69

1

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired from

(b) General nature of industry, business, or establishment in which employed (or employer)

Atlantic Business

(c) Name of employer

Company

9 BIRTHPLACE (city or town)
(State or country)

Baltimore
Maryland

10 NAME OF FATHER

David Owen Laws

11 BIRTHPLACE OF FATHER (city or town)

Ballo.

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Emily Ricketts

13 BIRTHPLACE OF MOTHER (city or town)

Ballo.

(State or country)

Maryland

14

Informant
(Address)

Mrs Katherine F. Laws (wife)
118 Hawthorne Road

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

May 10, 1922 to Oct 30, 1922

that I last saw him live on Oct 30, 1922

and that death occurred, on the date stated above, at 1.2 m.

The CAUSE OF DEATH* was as follows:

Leucemia

(duration) 3 hrs yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)

(duration) unknown yrs. — mos. — ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed)

Jeffries Burt M. D.

10/30/22 (Address)

2800 or 2800

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Grain Ridge Cemetery

Nov-1 1922

20 UNDERTAKER

STANLEY & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE

D 68765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68765

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Bolton ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hobbs Rogers Warner(a) RESIDENCE. NO. 1906 Bolton ST.: 14 WARD. Resident

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 23 ds. How long in U. S., if of foreign birth? 72 yrs. 10 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofElla Shriver Warner6 DATE OF BIRTH (month, day, and year) Dec-6-18497 AGE Years 72 Months 10 Days 23 If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired Long

(b) General nature of industry, business, or establishment in which employed (or employer)

Baltimore Trust

(c) Name of employer

Company9 BIRTHPLACE (city or town)
(State or country)Baltimore
Maryland10 NAME OF FATHER Michael Warner11 BIRTHPLACE OF FATHER (city or town)
(State or country)Baltimore
Maryland12 MAIDEN NAME OF MOTHER Julia Rogers13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Baltimore
Maryland14 Informant Mrs. Ella S. Warner (wife)
(Address) 1906 Bolton St. City15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29th 1922

17 I HEREBY CERTIFY, That I attended deceased from

July 1, 1922, to Oct. 28, 1922,that I last saw him alive on Oct 28, 1922,and that death occurred, on the date stated above, at 6.10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) 2 yrs. — mos. — ds.CONTRIBUTORY Acute Bronchitis
(Secondary) (duration) 8 yrs. — mos. — ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? — Date of —Was there an autopsy? —What test confirmed diagnosis? —(Signed) James C. Clark, M. D.(Address) Zaroke Apt. Chas. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park Cemetery Oct-31-1922

20 UNDERTAKER

ADDRESS

STEWART & MOWEN COMPANY
168 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 30 1922

D 68766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68766

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 260 S. Durham ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Garrison Green(a) RESIDENCE NO. 260 S. Durham ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE a. a. 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of married

6 DATE OF BIRTH (month, day, and year)

7 AGE 70 Years — Months — Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Magothy a. a. a.10 NAME OF FATHER Perry Green11 BIRTHPLACE OF FATHER (city or town) (State or country) Magothy a. a. a.12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mary Green (Address) 260 Durham St15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 19 2217 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 19 22, to Oct. 28, 19 22, that I last saw him alive on Oct. 28, 19 22, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Infirmitie of age -
Cystitis

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? homeDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) Rob Robinson, M. D.10/29/22 (Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Elkton, a. a. a. md

DATE OF BURIAL

Oct 31 19 22

20 UNDERTAKER

Edward Bryan Calver

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every fact should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OCT 30 1922

Burial Permit Clerk

D 68767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68767

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

415 Sumner St.

ST.

WARD) 5-90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emma Jackson

(a) RESIDENCE. No.

415 Sumner St.

ST.

WARD. 5

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 1/2 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

Colored

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

James W. Jackson

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Balt.

Md.

10 NAME OF FATHER

Sam'l Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mullman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)James Jackson
415 Sumner St.

15

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 1, 1922, to Oct. 28, 1922.

that I last saw him alive on Oct. 28, 1922.

and that death occurred, on the date stated above, at 6-10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

Robert J. Green, M. D.

10-29-1922 Address 126 Disgrace St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's Cemetery

Nov 1 1922

20 UNDERTAKER

ADDRESS 1631

Edward Bryan

Alonso

Physicians should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OCT 30 1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68768

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 S Gilman ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Maurice G + Mary A E Brownley(Residence in Baltimore: No. 429 S Gilman St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White5-SINGLE, single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Oct 30, 1922
(Month) (Day) (Year)

7-AGE,

..... yrs. mos. ds. 3 hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE,
(State or Country),Baltimore

10-NAME OF FATHER,

Maurice G Brownley11-BIRTHPLACE OF FATHER
(State or Country),Virginia

12-MAIDEN NAME OF MOTHER

Mary A E Phelps13-BIRTHPLACE OF MOTHER
(State or Country),Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maurice G Brownley(Address) 429 S Gilman St

15-

Robert P. Harrison

16-

101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 30, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 30 1922, to Oct 30 1922that I saw him alive on Oct 30 1922and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

premature birth
about 7 mo gest

..... (Duration) yrs. mos. ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) J. E. Moore M. D.Oct 30, 1922 (Address) 1520 Hollins

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

mt Olivet Cemetery Oct 30, 1922

20-UNDERTAKER

ADDRESS

John P. Gough 1520 Hollins

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

D 68769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68769

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1901 E. Lammale* ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Eliza A. De Wald

(a) RESIDENCE NO.

1901 E. Lammale ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Chas. H. De Wald*

6 DATE OF BIRTH (month, day, and year)

Nov. 23, 1869

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*52**11**6*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work*at home*(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Ind*

10 NAME OF FATHER

Daniel R. Wright

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ind

12 MAIDEN NAME OF MOTHER

Mary E. Patchett

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ind

14

Informant

(Address)

Charles H. De Wald
1901 E. Lammale

15

Filed

Robert P. Harrison,
19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 28 1922, to *Oct 29 1922*,that I last saw him alive on *Oct 29 1922*,and that death occurred, on the date stated above, at *8:15 P* m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration)

yrs.

mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922 (Address)

1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL*Lorraine*

DATE OF BURIAL

Oct 31 1922

20 UNDERTAKER

Zerkler & Zerkler

ADDRESS

1739
*Eager*N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE IS THE PROPERTY OF THE HEALTH DEPARTMENT AND SHOULD BE KEPT IN A SAFE PLACE. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1301922

Burial Permit No. 1212

D 68770

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68770

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Collins*, ST. *10* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Little Sister of Mr. Pm.*(a) RESIDENCE. NO. *Preston Valley St.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow of*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Francis Collins*6 DATE OF BIRTH (month, day, and year) *28 June 1852*7 AGE Years *70* Months *4* Days *—* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town). *Baltimore* (State or country) *Md.*10 NAME OF FATHER *Patrick Curney*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Margaret*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Little Sister of Mr. Pm.* (Address) *Preston Valley St.*15 Filed *19* Registrar *Robert P. Harrison*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 28 1922*17 I HEREBY CERTIFY, That I attended deceased from *to record* 19 *to* 19 *to*that I last saw him alive on *Oct 22* 19 *22*and that death occurred, on the date stated above, at *11:45 P.m.*

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy(duration) yrs. mos. ds. *3 weeks*CONTRIBUTORY (Secondary) *Coma*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. A. Warner* M. D.1922 Address *1133 Valley St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Peters**Oct 31 1922*

20 UNDERTAKER

ADDRESS

*W. C. Wiedefeld**914 Greenfield*

state should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCASION is very important. See instructions on back of certificates.

OCT 30 1922

Burial Permit Clerk

D 68771

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68771

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3103 Elliott

ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Annie Losovsky

(a) RESIDENCE. No. 3103 Elliott

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Alexander Losovsky

6 DATE OF BIRTH (month, day, and year)

1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

48

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Bohemia

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

14

Informant (Address)

Alexander Losovsky 3103 Elliott St.

15

Filed

Robert P. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 17, 1922, to Oct. 27, 1922,

that I last saw him alive on Oct. 27, 1922,

and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Kovak, M. D.

, 19 (Address) 801 N. Pratt St. W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cath. Hall

Oct. 30 1922

20 UNDERTAKER

ADDRESS

Frank Evans Son

1116 N. W. Ave.

PHYSICIANS should state EXACTLY. Exact statement of OCCASION should be stated EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1301522

D 68772 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68772

1-PLACE OF DEATH

City of BALTIMORE: (No. 135 So. Curley St., 1 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise C. Bogdan(Residence in Baltimore: No. 135 So. Curley St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Single6-DATE OF BIRTH, Oct 12 1920 (Month) (Day) (Year)7-AGE, 2 yrs. 17 mos. 17 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, Child (b) General nature of industry, business, or establishment in which employed (or employer).....9-BIRTHPLACE, (State or Country), Md10-NAME OF FATHER, Geo. A. Bogdan11-BIRTHPLACE OF FATHER, (State or Country), Md12-MAIDEN NAME OF MOTHER, Mollie Dietrich13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. A. Bogdan(Address) 135 So. Curley St

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 29 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry and that said deceased came to this death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis(Duration) 3 yrs. 3 mos. 3 ds.

CONTRIBUTORY (Secondary).....

(Signed) John B. Horton M. D. (Address) Curtis Bay*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Heart Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Holy Redeemer 10/31 192220-UNDERTAKER, ADDRESS J. G. Moran E. Balt.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JCT

1922

1922

Registrar.

D 68774

HEALTH DEPARTMENT—CITY OF BALTIMORE, D 68774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1822 E. Baltimore ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Coady

(A) RESIDENCE. No. 1822 E. Baltimore ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE white
5 Single, Married, Widowed, or Divorced (write the word) Single
5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb'y 14 1860

7 AGE Years 62 Months 8 Days
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER Michael Coady

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Lyons

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)14 Informant Ella Coady
(Address) 1822 E. Baltimore

15 Filed Robert E. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 27 1922 to Oct 29 1922, that I last saw him alive on Oct 28 1922, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Anterior poliomyelitis

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1822 E. Baltimore St.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edgar S. Perkins, M. D.

19 (Address) Rockville Md. W. K. Perkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Humbathedral born 10/31 1922

20 UNDERTAKER J. G. Moran ADDRESS 3000 E. Baltimore

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*I have attended patient about two
years for Arterio Sclerosis.*
Edw. S. Pugh M.D.
Arterio Sclerosis

D 68775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68775

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *4* mos. *0* ds.

How long in U. S., if of foreign birth?

yrs. *0* mos. *0* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced. (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James Davis

6 DATE OF BIRTH (month, day, and year)

Dec 15 - 1880

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*42**11**14*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert S. Harrison

Registrar

Burial Permit Clerk:

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 19 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 38, 1922 to Oct 29, 1922

that I last saw him alive on

Oct 29, 1922

and that death occurred, on the date stated above, at

5:30 p.m.

The CAUSE OF DEATH* was as follows

Myocardial Infarction
Coronary Artery Disease(duration) yrs. *4* mos. *0* ds.

CONTRIBUTORY (Secondary)

Toxemia Shock
(duration) yrs. *2* mos. *0* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *10-29-22*Was there an autopsy? *No*What test confirmed diagnosis? *Oper. signs*

(Signed)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

George A. Taylor

D 68776

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *5411* *Ward 1st.*) WARD

2-FULL NAME Morris Becker.

(A) RESIDENCE. NO. 2124 Herbert

ST. WARD.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(Usual place of abode)				(If nonresident give city or town and State)			
Length of residence in city or town where death occurred	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.

MEDICAL CERTIFICATE OF DEATH

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
-------	-----------------	---

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 - 1922

AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
7	1	8	11	

S OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER Morris Decker

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) ind

12 MAIDEN NAME OF MOTHER *Martha Tripp*

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) MD

14 Informant Ernie Becker
(Address) 2104 West 1st St

15 Robert P. Harrison,

Registrar

~~Burial Permit Clerk~~

16 DATE OF DEATH (month, day, and year) Oct. 29 1922

17 I HEREBY CERTIFY,* That I attended deceased from
Oct 17, 19 to Oct 29, 1922.

that I last saw him alive on Oct 29, 1922

and that death occurred, on the date stated above, at 11:00 P.m.

The CAUSE OF DEATH* was as follows:

Meningitis, epidemic.

(duration) 0 yrs. 1 mos. 18 ds

CONTRIBUTORY
(Secondary)

... (duration) yrs. mos. da.

18 Where was disease contracted
if not at place of death? *at home*

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Smears

(Signed) William Lawrence M. D.

10/3/19 (Address) *Hyd Beecham Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
--	----------------

20 UNDERTAKER

Oct 19 1941

ADDRESS

D 68777 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68777

CERTIFICATE OF DEATH. 159-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 Bowen Court ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO. 412 Bowen Court ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Cal 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 28/22

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 2 days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Harrison Cal

11 BIRTHPLACE OF FATHER (city or town) North Carolina (State or country)

12 MAIDEN NAME OF MOTHER Minnie Scott

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

PARENTS

14 Informant (Address)

15 Filed

Robert P. Harrison, Registrar

Registar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 28, 1922, to Oct 29, 1922

that I last saw him alive on Oct 29, 1922

and that death occurred, on the date stated above, at 2:00 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia - (Blue Baby) due to birth with placenta previa (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. M. E. Woodball, M. D.

, 19 (Address) 2248 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER

ADDRESS

Commissioner Health,

W. M. E. WOODBALL

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OCT 30 1922

Burial 11:00 AM

OCT 30 1922

D 68778

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68778

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. *Forrest Ave.* ST. *27* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *August Foss*(a) RESIDENCE NO. *Forrest Ave.* ST. *27* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *30* yrs. mos. ds. How long in U. S., if of foreign birth? *35* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of *Edith Foss* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 28-1863*7 AGE Years *29* Months *3* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Packer*(b) General nature of industry, business, or establishment in which employed (or employer) *Cigar Mfg.*

(c) Name of employer

9 BIRTHPLACE (city or town) *Germany* (State or country)10 NAME OF FATHER *Theodore Foss*11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)14 Informant *Edith Foss* (Address) *Forrest Ave.*15 *Robert P. Harrison,*Filed *19*

Registrar

Special Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/29/1922*17 I HEREBY CERTIFY, That I attended deceased from *April 12*, 1922, to *Oct 29*, 1922, that I last saw him alive on *Oct 27*, 1922, and that death occurred, on the date stated above, at *3:30* a. m.

The CAUSE OF DEATH* was as follows:

*Cerebral Hemorrhage*CONTRIBUTORY (Secondary) *Arteriosclerosis* (duration) *4* yrs. mos. ds.18 Where was disease contracted if not at place of death? *✓*Did an operation precede death? *No* Date of *✓*Was there an autopsy? *No*What test confirmed diagnosis? *Physical symptoms*(Signed) *Geo. H. Keller*, M. D.1429 1922 (Address) *1937 Gough St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Loudon Park* DATE OF BURIAL *10/31/1922*20 UNDERTAKER *Wm. Cook, 502 E. North Ave.* ADDRESS

PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

OCT 30 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68779

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3310 alto ave. ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W. Gilbert Isaac(a) RESIDENCE. NO. 3310 alto ave. ST. 15 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

N

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23, 1915

7 AGE

7

Years

Months

4

Days

6

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.
md.

10 NAME OF FATHER

W. G. Isaac.

11 BIRTHPLACE OF FATHER (city or town)

Balto.

(State or country)

md.

12 MAIDEN NAME OF MOTHER

Cora M. Roberts

13 BIRTHPLACE OF MOTHER (city or town)

Balto.

(State or country)

md.

14

Informant

(Address) W. G. Isaac
3310 alto ave.

15

Filed

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 18, 1922 to Oct 29, 1922that I last saw him alive on Oct. 29, 1922and that death occurred, on the date stated above, at 9:40 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Interstitial
Nephritis. Uremia.
over(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cardiac Hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? urine & eye(Signed) Wm. G. Isaac, M. D.19 (Address) 3501 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Woodlawn10/31/19

20 UNDERTAKER

ADDRESS

Wm. Cook, 502 E. North Ave.

WRITE PLAINLY, WITH UNFADING INK
N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D 68780

CERTIFICATE OF DEATH

D 68780

PLACE OF DEATH
CITY OF BALTIMORE (No. 706 Beaumont Ave ST. 27 WARD)
2-FULL NAME Catherine E. Maguire
(Residence in Baltimore: No. 706 Beaumont Ave St. 10 yrs. mos. da.)

REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 1 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word)

6 DATE OF BIRTH Aug. 31, 1897 (Month) (Day) (Year)

7 AGE 15 yrs. 1 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION (a) Trade, profession, or particular kind of work School Teacher (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Cumberland Md.

PARENTS

10 NAME OF FATHER John J. Maguire

11 BIRTHPLACE OF FATHER (State or country) Penn.

12 MAIDEN NAME OF MOTHER Cath. Shaughnessy

13 BIRTHPLACE OF MOTHER (State or country) UNKNOWN

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Catherine Maguire (Address) 706 Beaumont Ave.

15. Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 28, 1922 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14, 1922 to Oct 27, 1922 that I saw h alive on Oct 27, 1922 and that death occurred, on the date stated above, at 5 A m. The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) yrs. 6 mos. 2 ds

Contributory Exhaustion (SECONDARY) (Duration) yrs. mos. ds.

(Signed) Stanley M. Nelson M. D. Oct 30, 1922 (Address) 1609 Hudson Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cathedral Ave DATE OF BURIAL Oct 31, 1922

20-UNDERTAKER Margaret J. Thompson ADDRESS 1417 Light St.

D 68781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68781

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *10* ST. *Belmont* WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

58 yrs. 7 mos. 16 ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Florence E. Hartman

6 DATE OF BIRTH (month, day, and year)

Nov 13-1863

7 AGE

58

Years

7

Months

16

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Restauranter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Fredk. Hartman

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Freda Hummel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Florence E. Hartman

8 Belmores Ave

15

Filed

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 27 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 26, 1922, to Oct. 27, 1922.

that I last saw him alive on Oct 27, 1922,

and that death occurred, on the date stated above, at 10:15 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculum Peritonitis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

da.

18 Where was disease contracted

if not at place of death?

At home

Did an operation precede death?

Yes

Date of

Oct. 26-1922

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

F.A. Krause & Son

703 Hanover

D 68782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68782

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Greentree(a) RESIDENCE No. 728 Cumberland St

(Usual place of abode)

ST. 15 WARD

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Andrew J. Greentree

6 DATE OF BIRTH (month, day, and year)

Dec. 17 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84 10 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John Eockinston

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore, Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant

Municipal Hospital Records

(Address)

15

OCT 31 1922

ROBERT R. KRAUTER,

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1922

17

I HEREBY CERTIFY, That I attended deceased from October 3, 1922 to October 29, 1922.that I last saw her alive on October 29, 1922.and that death occurred, on the date stated above, at 10:10 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? YesWhat test confirmed diagnosis? APN, Pkth, BP, etc(Signed) Chas. M. Hentz M. D.Address 1111 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park

DATE OF BURIAL

Oct 31 1922

20 UNDERTAKER

Mrs. Mrs. John W. Tenzel & Son

ADDRESS

801 N. Fayette

ation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68784

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *1511* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Alexander Lane

(Residence in Baltimore: No. *1619* *N. Calhoun* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *Black* 5-~~Single~~, *Married*, *Widowed* or Divorced, (Write the word.)

6-DATE OF BIRTH, *Sept 29*, 18*95* (Month) (Day) (Year)

7-AGE, *27* yrs. *1* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer), *040*

9-BIRTHPLACE, (State or Country), *Calvert Co Md*

10-NAME OF FATHER, *Mrs N. Lane*

11-BIRTHPLACE OF FATHER, (State or Country), *Calvert Co Md*

12-MAIDEN NAME OF MOTHER, *Susie A. Young*

13-BIRTHPLACE OF MOTHER, (State or Country), *Calvert Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary Lane (Wife)*

(Address) *1619 N. Calhoun St*

15- Filed *OCT 31 1922* *ROBERT R. KRAUTER,* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 29*, 192*2* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* find that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Peritonitis - due to ruptured appendix

(Duration) yrs. mos. ds.

CONTRIBUTOR (Secondary) *(P.M. at Hosp)*

(Signed) *J. St. Hall* (Duration) yrs. mos. ds.

(Coroner.) *Oct 30 1922* (Address) *505 E. North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Fisher Station and Nov. 1st, 192*2*

20-UNDERTAKER, ADDRESS

Joseph A. Farrell *2319 Division St*

D 68785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 S. Chester ST., 1 WARD)

2-FULL NAME

Lillian M. Uphoff

(a) RESIDENCE No.

315 S. Chester

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Lifetime

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 1-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Edward Uphoff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Lillian Lyons

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant

Edward Uphoff

(Address)

315 S. Chester St

15

Filed

19

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 17, 1922, to Oct. 30, 1922

that I last saw him alive on Oct 28, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Persano M. D.

1030 1922 (Address) 2nd Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Oak Lawn Cem

Oct 31 1922

20 UNDERTAKER

ADDRESS

Chas P. Evans & Son 1180 Mt Royal Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68786

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68786

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Edmondson ST.; 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Catherine Fisher

(a) RESIDENCE. NO.

1817 Edmondson ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

f

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Otto Fisher

6 DATE OF BIRTH (month, day, and year)

Feb 28 - 1846

7 AGE

76

Years

Months

8

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Bro Helwig

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Caroline Herrman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Brother Henry Helwig 2822 E. Baltimore

15

Filed

19

ROBERT R. KRAUSE

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1st 1922 to Oct 30th 1922

that I last saw her alive on Oct 30th 1922

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Filoid Phthisis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. J. M. D.

19 (Address) 400 N. Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

Nov 1 1922

20 UNDERTAKER

ADDRESS

George Smith

Fayette

D 68787

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68787

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4312 E Lombard St. WARD 113)

2. FULL NAME

(a) RESIDENCE NO. 4312 E Lombard St. WARD 113(Usual place of abode)
Length of residence in city or town where death occurredyrs. 3 mos. 5 ds.(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

MaleWhiteSingle5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofnone

6 DATE OF BIRTH (month, day, and year)

July 25/1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.35

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore Md

10 NAME OF FATHER

Louis J Foy11 BIRTHPLACE OF FATHER (city or town)
(State or country)Chockine Pa

12 MAIDEN NAME OF MOTHER

Anna Atkins13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Pottsville Pa

14

Informant
(Address)Louis J. Foy
4312 E Lombard St.

15

Filed

OCT 31 1922

19

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 30 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct 25, 19 22, to Oct 30, 19 22that I last saw him live on Oct 20, 19 22and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Auto intoxication
Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date of noWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Maxwell L. Meyer M. D.(Address) 315 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALOak Lawn

20 UNDERTAKER

John & Denny

DATE OF BURIAL

Oct 31 19 22

ADDRESS

715 Light St

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

ation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

D 68788 HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. *St Agnes Hospital 23* ST. *23* WARD)

2-FULL NAME

(a) RESIDENCE NO. *2300 Race St* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F.* 4 COLOR OR RACE *W.* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Frank Flamm*

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *58 yrs*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*

10 NAME OF FATHER *Do not know*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *"*

12 MAIDEN NAME OF MOTHER *"*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *"*

14 Informant *Frank Flamm* (Address) *2300 Race St*

15 Filed *19* *ROBERT R. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10-29* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *10-18*, 19 *22*, to *10-29*, 19 *22*.

that I last saw him alive on *10-29*, 19 *22*.

and that death occurred, on the date stated above, at *4:30 P.* m.

The CAUSE OF DEATH* was as follows:

Pneumonia secondary to Pulmonary Tuberculosis

(duration) *?* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Cancer of Liver* *Symptoms first noted 3 mos.* ds.

18 Where was disease contracted? *?* if not at place of death?

Did an operation precede death? *Yes* Date of *10/19/22*

Was there an autopsy? *Not permitted*

What test confirmed diagnosis?

(Signed) *H. Harper* M. D.

, 19 (Address) *St. Agnes Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL *Oaklawn Cemetery* DATE OF BURIAL *Nov 2, 1922*

20 UNDERTAKER *F.A. Krause & Son* ADDRESS *703 Danvers*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68789

CERTIFICATE OF DEATH.

101-001
D 68789
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 W. Cross St.

ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James G. Skleres.

(a) RESIDENCE NO.

136 W. Cross St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male.

White.

Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14, 1922.

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

5

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

None.

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

John Skleres.

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Greece.

12 MAIDEN NAME OF MOTHER Ethel Valkas.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Greece.

14

Informant
(Address)John Skleres. (father).
136 W. Cross St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 30, 1922.

17

I HEREBY CERTIFY, That I attended deceased from
October 29, 1922, to October 30, 1922.

that I last saw him alive on October 30, 1922.

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) -- yrs. -- mos. 2 ds.

CONTRIBUTORY
(Secondary)

Apnoea.

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? NO. Date of

Was there an autopsy? NO.

What test confirmed diagnosis? Clinical diagnosis.

(Signature) O. M. Reinhardt M. D.

Oct 30, 1922 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Woodlawn Cemetery Nov 1, 1922

20 UNDERTAKER

ADDRESS

F. A. Krause & Son 703 W. Avenue

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68790

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *18 Warner or Mt Vernon* ST.; *25* WARD)

REGISTERED NO. C

2-FULL NAME

Wm a Campbell

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *18 Warner*St.; *30* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *M* 4-COLOR OR RACE, *Cold* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) *Married*6-DATE OF BIRTH, *unknown*, 1 (Month) (Day) (Year)7-AGE, *46* yrs. mos. ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Ship Rigger* (b) General nature of industry, business, or establishment in which employed (or employer) *186*9-BIRTHPLACE, (State or Country) *St Vincent or India*

PARENTS.	10-NAME OF FATHER, <i>unknown</i>
	11-BIRTHPLACE OF FATHER (State or Country), <i>W. India</i>
	12-MAIDEN NAME OF MOTHER <i>unknown</i>
	13-BIRTHPLACE OF MOTHER (State or Country), <i>W. India</i>

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Susan A Campbell*(Address) *18 Warner or*

15-

Filed *OCT 3 1 1922* 101

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

10 (Month) *29* (Day), *1922* (Year)17- I HEREBY CERTIFY, That I attended deceased from *July 7* 1922, to *Oct 26* 1922, that I saw him alive on *Oct 26* 1922, and that death occurred, on the date stated above, at *2:50* m.

The CAUSE OF DEATH* was as follows:

*Paralysis of left side*CONTRIBUTORY (Secondary) *2nd stroke Oct 20-22*(Signed) *J B Hall* M. D. *10.30, 1922* (Address) *Halethorp*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn Cemetery Nov 1, 1922

20-UNDERTAKER

Mrs Robert A Elliott ADDRESS *1725 Ashland Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 68791

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 68791

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2442 Buchanan St. WARD 12)2-FULL NAME Berenice Elizabeth Stith(a) RESIDENCE NO. 2442 Buchanan St. WARD 12

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) single5a If married, widowed, or divorced HUSBAND of (or) WIFE of child6 DATE OF BIRTH (month, day, and year) July 19217 AGE Years 1 Months 3 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) in Baltimore (State or country)10 NAME OF FATHER Russell Stith11 BIRTHPLACE OF FATHER (city or town) va (State or country)12 MAIDEN NAME OF MOTHER Bindia Hick13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)14 Informant Elizabeth Stith (Address) 2442 Buchanan St.15 Filed OCT 3 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 192217 I HEREBY CERTIFY, That I attended deceased from Oct 26, 1922, to Oct 29, 1922, that I last saw her alive on Oct 29, 1922, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteric Intoxication(duration) yrs. mos. ds. 4CONTRIBUTORY Same as above (Secondary)(duration) yrs. mos. ds. 418 Where was disease contracted if not at place of death? unknownDid an operation precede death? no Date of noWas there an autopsy? noWhat test confirmed diagnosis? Physical Exam(Signed) Geo. Hall M. D., 19 (Address) 426 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel Cemetery

DATE OF BURIAL

Nov 1, 1922

20 UNDERTAKER

Mrs Robert A ElliottADDRESS 728Ashland St

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

D 68792 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68792

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3070 Exeter

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Catharine Kelleher

(a) RESIDENCE. No.

3070 Exeter

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Patrick Kelleher

6 DATE OF BIRTH (month, day, and year)

Nov 25 1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Thomas Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Ann Shannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Mary Kelleher 3070 Exeter

15

Filed

OCT 31 1922

ROBERT R. KRASNER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan. 1, 1922, to Oct 30, 1922, that I last saw him alive on Oct 25th, 1922

and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

no

Did an operation precede death? Date of

no

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. J. P. S. M. D. 10. 31. 22, 2nd Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Nov 2 1922 ADDRESS

Wm. J. Wyckson 373 Hill

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

D 68793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Taylor

(a) RESIDENCE NO. 244 N. Mount St

ST. 19 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

6a If married, widowed, or divorced

HUSBAND or WIFE of

Sadie E. Taylor

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50

--

--

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Unknown

9 BIRTHPLACE (city or town) (State or country)

Balto., Md

10 NAME OF FATHER

Henry Taylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER Eliza Johnson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant (Address)

Municipal Hospital Records

15

Filed

OCT 31 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 28 19 22

17

I HEREBY CERTIFY, That I attended deceased from Sept. 23 19 22, to October 28 19 22, that I last saw him alive on October 28 19 22, and that death occurred, on the date stated above, at 8:00 P.M. The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Infectious arthritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed)

J. A. Weckert M. D.

10/28/22 Address Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

ROYAL

20 UNDERTAKER

Samuel Henry

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68794

CERTIFICATE OF DEATH.

90 D 68794

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosptl ST. 27 WARD)

2. FULL NAME JOSEPH VINCENT KUHN

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 204-Oakdale-Road.
(Usual place of abode)

ST. 27 WARD Resident

Length of residence in city or town where death occurred 55 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 78 yrs. 3 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Hyland Kuhns

6 DATE OF BIRTH (month, day, and year) July-23-1844

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
78 3 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from 045

(b) General nature of industry, business, or establishment in which employed (or employer) Commission Merchant

(c) Name of employer Industry.

9 BIRTHPLACE (city or town) Littlestown
(State or country) Penna.

10 NAME OF FATHER William Kuhns

11 BIRTHPLACE OF FATHER (city or town) Littlestown
(State or country) Penna

12 MAIDEN NAME OF MOTHER Martha Eickenrode

13 BIRTHPLACE OF MOTHER (city or town) Littlestown
(State or country) Penna.14 Informant Chas. F. Kuhns, (son)
(Address) 204-Oakdale Road, Roland Park.15 OCT 31 1922 ROBERT R. KRAUTER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 11, 1922, to Oct 30, 1922,

that I last saw him alive on Oct 30, 1922,

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY Cardiac Decompensation
(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Doubt known.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) R. D. Harman, M. D.

19 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

NEW CATHEDRAL CEMETERY NOV-2-22 19

20 UNDERTAKER STEWART & MOWEN COMPANY
(WILLIAM F. WOODEN, Successor)

ADDRESS 103 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 lks.

D 68795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68795

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1838 E. Pratt St. ST., 7 WARD)

2-FULL NAME

Anna Gaacklein

(a) RESIDENCE NO. 1838 E. Pratt ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Gaacklein

6 DATE OF BIRTH (month, day, and year) Nov. 21 - 1843

7 AGE Years 78 Months 10 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Simon Barnickel

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Elizabeth Deinlein (Daughter)
1838 E. Pratt St.

15

Filed

19

ROBERT H. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 28 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 15, 1922, to Oct. 29, 1922, that I last saw him alive on Oct. 28, 1922, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Aortic + Mitral Regurg.
Auricular Fibrillation
Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Chronic Intestinal Nephritis

18 Where was disease contracted if not at place of death?

No

Did an operation precede death? Date of

No

Was there an autopsy?

No

What test confirmed diagnosis?

Clinical Exam. + Laboratory

(Signed)

A. F. Kuo

M. D.

Oct. 28 1922 (Address)

24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Holy Redeemer Ch.

DATE OF BURIAL

Nov. 3 1922

20 UNDERTAKER

Lilly & Zieher

ADDRESS

403 S. Wolfst.

ation should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

268796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84268796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mamie Lutz

(a) RESIDENCE NO. 52 E. Chester St. CITY

WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced

Elizabeth Frankenburg

6 DATE OF BIRTH (month, day, and year) March, 16, 1884

7 AGE 38 Years 7 Months 14 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER John L. Frankenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Kinnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant Johns Hopkins Hospital

15

Filed , 19

UGT 3 1 1922

ROBERT H. KRAUTER

Serial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 28, 1922, to Oct. 30, 1922, that I last saw her alive on Oct 30, 1922,

and that death occurred, on the date stated above, at 12:50, m.

The CAUSE OF DEATH* was as follows:

Brain tumor, left cerebral glioma

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date Oct 28

Was there an autopsy? Partial head

What test confirmed diagnosis? Operation

(Signed) F. L. Reichert M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Cem.

20 UNDERTAKER

Lilly and Zeile

DATE OF BURIAL

Nov. 2 1922

ADDRESS

403 W. 1st St.

D 68797 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68797

D

CERTIFICATE OF DEATH.

D

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No.

ST.:

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.:

yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, That I attended deceased from

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed)

10:20:00, 1922 (Address) 811 V. Street

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement on back of certificate. Important. See instructions on back of certificate.

15-

Filed

ROBERT R. KRAUTER,

Burial Permit Clerk.

D 68798 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Stevenson(a) RESIDENCE NO. Unknown
(Usual place of abode)ST., Unknown WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18847 AGE Years Months Days If LESS than 1 day, hrs or min. 38 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records,(Address) Municipal Hospital.

15

Filed

19

OCT 31 1922

ROBERT R. KRAUTER,

Registrar

Permit Clerk

20 UNDERTAKER

Commissioner Health,

Per. Wm. H. WOODALL.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26 19 2217 I HEREBY CERTIFY, That I attended deceased from March 29, 19 22, to October 26, 19 22, that I last saw her alive on October 26, 19 22, and that death occurred, on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:Acute myocardial insufficiency
overCONTRIBUTORY (Secondary) Myocardial insufficiency
(duration) yrs. mos. ds. (duration) yrs. mos. ds. 7

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Clyde M. Hall, M. D.10/30/22 address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

ADDRESS

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

probably Luetic.

D 68799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *25* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *14 N. 14th St. Fairfield, Md.* ST. _____ WARD. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Oct 29, 1922*

7 AGE Years Months Days If LESS than 1 day, 5 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country) *Maryland*10 NAME OF FATHER *William Isross*11 BIRTHPLACE OF FATHER (city or town) *Calvert County*
(State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Elizabeth Henson*13 BIRTHPLACE OF MOTHER (city or town) *Calvert County*
(State or country) *Maryland*

14

Informant
(Address)

15

Filed _____, 19

ROBERT R. KRAUTER,
RegistrarBurial Permit Clerk.
19630

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 29* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

Oct 29, 19*22*, to *Oct 29*, 19*22*.that I last saw him alive on *Oct 29*, 19*22*.and that death occurred, on the date stated above, at *10 P* m.

The CAUSE OF DEATH* was as follows:

*Prematurity
(24 weeks)*

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)*Placenta Praevia (Maternal)*

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. Norwood Wilson*, M. D., 19 (Address) *University Hospital*

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

19

20 UNDERTAKER

Commissioner Health,

ADDRESS

OCT 31 1922

Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

OCT 31 1922

D 68800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 N. Carlton

ST.: 18 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Barbara Hall

(Residence in Baltimore: No. 222 N. Carlton

St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Col.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

September, 1 (Month) (Day) (Year)

7-AGE,

64

If LESS than 1 day.

yrs. mos. da. hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housework

9-BIRTHPLACE,

(State or Country).

Maryland

10-NAME OF FATHER,

John Elliott

11-BIRTHPLACE OF FATHER

(State or Country).

Carroll Co., Md.

12-MAIDEN NAME OF MOTHER

Avery Holmes

13-BIRTHPLACE OF MOTHER

(State or Country).

Carroll Co., Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Mrs. Mary Lita Brooks

(Address).

222 N. Carlton St.

15-

Filed

OCT 31 1922

ROBERT R. KRAUTER,

101

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

October 30, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 1 1922, to Oct 30 1922,

that I saw her alive on Oct 30 1922,

and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) yrs. mos. da. 30

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da. 2

(Signed) C. D. Drouillard M. D.

Oct 30, 1922 (Address) 1211 M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,

Mt. Auburn Cemetery

DATE OF BURIAL,

November 1, 1922

20-UNDERTAKER

Mrs. Kate R. Williams

ADDRESS

11425 Saratoga St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.
Exact statement of OCCUPA-
tion should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

268801

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

268801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital ST. 11 WARD)

2-FULL NAME Jerry Clark

(a) RESIDENCE NO. 227 Chase street

(Usual place of abode)

ST. 11 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years 62 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Jack Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mathalie Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) H. J. H.

15 067311922 ROBERT R. KRAUTER, Registrar
Filed 31 1922 Serial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 26, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1922 to Oct. 26, 1922.

that I last saw him alive on Oct. 26, 1922.

and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows:

pulmonary tuberculosis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray
(Signed) Francis L. Indigliacca, M. D.

10-27-22 (Address) Municipal tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

W. J. McBurney & Co. Oct 31 1922
Samuel Taylor Oct 9 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68802

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME, Marie Hall(a) RESIDENCE NO. Unknown(Usual place of abode)
Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST., Unknown WARD

WARD

(If non-resident give city or town and State)

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) 18517 AGE Years Months Days If LESS than 1 day, hrs or min. 71 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cuba10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Hospital Records
(Address) Municipal Hospital.

15

Filed

Burlat Permit

16 DATE OF DEATH (month, day, and year) Oct. 29 19 2217 I HEREBY CERTIFY, That I attended deceased from October 20, 19 22, to October 29, 19 22.that I last saw her alive on October 29, 19 22.and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial
insufficiency

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Arteriosclerosis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Chas. M. Mearns M. D.10/30/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Information should be carefully supplied. Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68804

CERTIFICATE OF DEATH.

89 D 68804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Cathedral Street ST. 11 WARD)

2-FULL NAME

Walter Brewster Platt

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

802 Cathedral Street

ST. 11 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? Native mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Mary Terine Platt

6 DATE OF BIRTH (month, day, and year)

December 20 1853

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

68

10

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Waterbury, Conn

10 NAME OF FATHER

Gideon L. Platt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Middletown, Connecticut

12 MAIDEN NAME OF MOTHER

Caroline Tudor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Windsor, Connecticut

14

Informant

(Address)

Washington Platt

802 Cathedral St. Baltimore

15

Filed

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1922, to Oct 30, 1922.

that I last saw him alive on October 29, 1922.

and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary)

Hypertension; Arterio Sclerosis; Angina pectoris

(duration) 7 yrs. 10 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? physical examination

(Signed) Alan C. Sutton, M. D.

, 19 (Address) 1107 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Greenmount Cem

Nov 1st 1922

20 UNDERTAKER

ADDRESS

Henry Jenkins & Son, Co

Crescent, Baltimore

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68805

CERTIFICATE OF DEATH.

X 75-002 D 68805

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Mt Hope Retreat

ST. 28th WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Jeremiah Gooney (Bro. Cyril)

(a) RESIDENCE. NO.

Mt Hope Retreat

ST. 28 WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

0 yrs. 2 mos. 14 ds.

How long in U. S., if of foreign birth? Don't know ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

abt

67

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

Religion

(c) Name of employer

Cook

9 BIRTHPLACE (city or town) (State or country)

Ireland

10 NAME OF FATHER

Patrick Gooney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cork

12 MAIDEN NAME OF MOTHER

Hanna Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Cork

14 Informant (Address)

Records of Mt Hope

15 Date

1922

16

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 21st 1922

17 I HEREBY CERTIFY, That I attended deceased from

Aug 7th 1922, to Oct 31st 1922,

that I last saw him alive on Oct 31, 1922,

and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis (Para-plegia)

abt (duration) 0 yrs. 3 mos. 0 ds.

CONTRIBUTORY Dementia Senile

(Secondary) abt (duration) 1 yrs. 2 mos. 0 ds.

18 Where was disease contracted Balto Md

If not at place of death? No Date of

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis?

Signed Frank J. Flannery, M. D.

31, 1922 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cremendale Md.

20 UNDERTAKER

George E French Laurel

Md.

Station should be carefully examined to determine if there is any statement of death in plain terms, so that it may be properly classified. Exact statement of death in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

D 68806 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68806

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 9th St. ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Margaret Ann Cooper

(a) RESIDENCE NO.

305-9th St.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Errett Cooper

6 DATE OF BIRTH (month, day, and year)

Aug. 10/1840

7 AGE

Years

Months

Days

LESS than 1 day, hrs. or min.

82

2

19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home wife

(b) General nature of industry, business, or establishment in which employed (or employer)

Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

md.

14

Informant (Address)

Margaret A. Cooper
502 E. Johns St.

15

Filed

Robert P. Harrison

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct. 29, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 27, 1922 to Oct 29, 1922

that I last saw her alive on Oct 29, 1922

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration)

yrs.

mos.

3 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Exam

(Signed)

Robert P. Harrison M. D.

(Address) 3347 Chestnut St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

UNDERTAKER

ADDRESS

New Cathedral Cem.
Chenoweth & Son

3617 Chestnut St.

31 1922

D 68807

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68807

CERTIFICATE OF DEATH. X 90 ✓

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Schley Ave.

ST. 27 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Daniel G. Girelius

(a) RESIDENCE NO. 6 Schley Ave. Gardenville Md

ST. 27 WARD

Vineland N. J.

Length of residence in city or town where death occurred

yrs. 1 1/2 mos.

ds.

How long in U. S., if of foreign birth? 53

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of Anna Regina Girelius (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1835

7 AGE 86 Years 10 Months 19 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer (retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sweden (State or country)

10 NAME OF FATHER Lars Daniel Girelius

11 BIRTHPLACE OF FATHER (city or town) Sweden (State or country)

12 MAIDEN NAME OF MOTHER Sara Gustava Westman

13 BIRTHPLACE OF MOTHER (city or town) Sweden (State or country)

14 Informant Chas. Girelius (Address) 6 Schley Ave. Gardenville Md.

45 1922 Robert F. HARRISON,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1922, to Oct. 30, 1922,

that I last saw him alive on Oct. 29, 1922,

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

10/30, 1922 (Address) Rosedale, Md.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Vineland New Jersey

20 UNDERTAKER

Fred G. Harrison

DATE OF BURIAL

Nov. 1st 1922

ADDRESS

Vineland N. J.

Information should be carefully supplied. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 68808

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68808

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle Deamer(a) RESIDENCE NO. 1972 E. Fayette ST. 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Deamer6 DATE OF BIRTH (month, day, and year) 18837 AGE Years 39 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife(b) General nature of industry, business, or establishment in which employed (or employer) —(c) Name of employer —9 BIRTHPLACE (city or town) (State or country) Md.10 NAME OF FATHER George Schultz11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.12 MAIDEN NAME OF MOTHER Emma Deams13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.14 Informant Johns Hopkins Hospital (Address)15 Robert T. Harrison, Registrar

Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29th 192217 I HEREBY CERTIFY, That I attended deceased from Oct 29th 1922 to Oct 29th 1922that I last saw him alive on Oct 29th 1922and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(duration) ? yrs. mos. ds.CONTRIBUTORY Pregnancy and labor (Secondary)(duration) ? yrs. mos. ds.18 Where was disease contracted if not at place of death? ?Did an operation precede death? yes Date of Oct 29/22Was there an autopsy? yesWhat test confirmed diagnosis? Autopsy(Signed) W. B. Gray, M. D., 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL New Cathedral Cem DATE OF BURIAL 10/2 192220 UNDERTAKER J. A. Moran ADDRESS 300E. Balt.

Information should be carefully supplied. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68809

CERTIFICATE OF DEATH.

D 68809

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1306 Glyndon Br. ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis L. Brown

(a) RESIDENCE. No. 1306 Glyndon ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 20 - 1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 21 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 27, 1922, to Dec 21, 1922,

that I last saw him alive on Dec 20, 1922,

and that death occurred, on the date stated above, at 6:04 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Harrison, M. D.

1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

3 1922

Burial Permit Clerk.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Primary

HEALTH DEPARTMENT—CITY OF BALTIMORE,

159367
D 68810

CERTIFICATE OF DEATH.

114 D 68810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edna Forrest

(a) RESIDENCE No.

208 N. Annapolis St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Black Married

5a If married, widowed, or divorced

HUSBAND
(or) WIFE ofArchie Forrest

6 DATE OF BIRTH (month, day, and year)

Feb 1897

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto
Maryland

10 NAME OF FATHER

Edna

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Edna

12 MAIDEN NAME OF MOTHER

Alma Lawton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Edna

14

Informant
(Address)JOHNS HOPKINS HOSPITAL

15

Filed

NOV 1 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 24 1922, to Oct 30 1922that I last saw her alive on Oct 30 1922and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Ulcer of descending colon, perforated
& peritonitis.Peritonitis came of death(duration) 2 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

Ulcer of descending colon

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

?Did an operation precede death? yes Date of 10-30-22Was there an autopsy? yesWhat test confirmed diagnosis? autopsy(Signed) K. H. M. J. H., M. D., 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Johns Hopkins HospitalNov 2 1922

ADDRESS

578
W. B. D. H.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D68811

See Letter of Nov 3-1922 from C. Lockard M.D.
HEALTH DEPARTMENT CITY OF BALTIMORE D 68811

CERTIFICATE OF DEATH

PLACE OF DEATH
CITY OF BALTIMORE (No. 27 ST. 27 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
FULL NAME Marcellus J. Roche
(Residence in Baltimore: No. 27 St. 27 yrs. 27 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single (If write the words)
6 DATE OF BIRTH 4/12/12 (Month) (Day) (Year)
7 AGE 10 yrs. 6 mos. 16 ds. If LESS than 1 day, hrs. or min.?
8 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)
9 BIRTHPLACE (State or country) md
PARENTS
10 NAME OF FATHER Samuel Roche
11 BIRTHPLACE OF FATHER (State or country) md
12 MAIDEN NAME OF MOTHER Anna Byrne
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Samuel Roche
(Address) 27

15.

Filed

191

ROBERT R. KRAUTER,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov. 1, 1922
Oct 30th (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28, 1922, to OCT 30, 1922, that I saw him alive on OCT. 28, 1922, and that death occurred, on the date stated above, at 6:30 m. The CAUSE OF DEATH* was as follows:

Miliary tuberculosis.

(Duration) About 6 weeks yrs. mos. ds.

Contributory (SECONDARY)

(Signed) G. Carroce Lockard M. D.
Nov. 1, 1922 (Address) 4 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Luke's

11/1/22

20 UNDERTAKER

ADDRESS

John J. P. & Son

13. S. Light

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 Sharp ST., 23 WARD)2-FULL NAME James Gray(a) RESIDENCE NO. 925 Sharp ST., 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 1/2 yrs. mos. ds.(If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col. 5 Single, Married, Widowed, or Divorced, (write the word) never5a If married, widowed, or divorced
HUSBAND of ✓
(or) WIFE of ✓6 DATE OF BIRTH (month, day, and year) Sept 217 AGE Years Months Days If LESS than 1 day, hrs. or min. 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓(b) General nature of industry, business, or establishment in which employed (or employer) ✓(c) Name of employer ✓9 BIRTHPLACE (city or town) Baltimore
(State or country)10 NAME OF FATHER Clarence Gray11 BIRTHPLACE OF FATHER (city or town) Ind.
(State or country)12 MAIDEN NAME OF MOTHER Mary Elkins13 BIRTHPLACE OF MOTHER (city or town) Ind.
(State or country)

14

Informant Mary Elkins
(Address) 925 - 8 Sharp St

15

ROBERT M. KRAUTER,
Filed NOV 1 - 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 19 22

17

I HEREBY CERTIFY, That I attended deceased from Oct 27, 19 22, to Oct 31, 19 22,
that I last saw him alive on Oct 31, 19 22.that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
the whooping cough
(duration) yrs. mos. ds. 4CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? ✓Did an operation precede death? no Date of ✓Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) W. H. Lawrence M. D.11, 192 (Address) 1400 Hill St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Int. Aurlin Cemetery

20 UNDERTAKER

Mrs. Robert A. Elliottashland

DATE OF BURIAL

Nov 1 19 22

ADDRESS

1725ashland

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be properly classified, so that it may be properly classified. Exact statement of occupation state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68813

D 68813

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 607 Brent St., 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Maggie Libson

(Residence in Baltimore: No. 607 Brent St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, Black
5-SINGLE, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Nov 21, 1868
(Month) (Day) (Year)

7-AGE, 53 yrs. 11 mos. 24 ds.
If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, At Home
(b) General nature of industry, business, or establishment in which employed (or employer), formerly a cook

9-BIRTHPLACE, Va
(State or Country),

10-NAME OF FATHER, John Walker

11-BIRTHPLACE OF FATHER, Va
(State or Country),

12-MAIDEN NAME OF MOTHER, Rosa unknown

13-BIRTHPLACE OF MOTHER, Va
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Barker (Maiden)

(Address) 607 Brent St

15-ROBERT R. KRAUTER, Registrar.

Filed NOV 1-1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 28, 1922
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Valvular Insufficiency as Coroner

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart & Arteries for simple yrs ago

(Duration) yrs. mos. ds.

(Signed) J. S. H. Coroner.

10-30-1922 (Address) 505 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery

DATE OF BURIAL, Oct 1, 1922

20-UNDERTAKER, Mrs R A Elliott

ADDRESS, Oakland Ave

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68814

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3 WARD)2. FULL NAME Mary Maciejaska Petronell Macyeski(a) RESIDENCE NO. 1511 E. Lombard St. ST. 4 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 19 yrs. ? mos. ? ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
or WIFE ofChorfanie Smith (Daughter)6 DATE OF BIRTH (month, day, and year) ?7 AGE 41 Years Months ? Days ?

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Houskeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania
(State or country)10 NAME OF FATHER John Slavckas11 BIRTHPLACE OF FATHER (city or town) Lithvania
(State or country)12 MAIDEN NAME OF MOTHER Nok.13 BIRTHPLACE OF MOTHER (city or town) Lithvania
(State or country)14 Informant (Address) JOHNS HOPKINS HOSPITAL
1511 E. Lombard Street15 NOV 1-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct. 20, 1922, to Oct 30, 1922.that I last saw her alive on Oct 30, 1922.and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Oct. 31-1922Was there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) Chas. ReBuag, M. D., 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. StanislovasNov 2th 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas425 S Paca S

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68815

CERTIFICATE OF DEATH.

90 D 68815

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO

1106 William

ST.

WARD)

2-FULL NAME

Katherine Goodwin

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

1106 William

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

38

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed,

or Divorced (write the word)
Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

James Goodwin

6 DATE OF BIRTH (month, day, and year)

Dec 25-1883

7 AGE

Years

Months

Days

If LESS than

38

10

4

1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer)

Factory

(c) Name of employer

9 BIRTHPLACE (city or town)

Baltimore Md.

(State or country)

10 NAME OF FATHER

Charles D. Bauer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Katherine Ott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant

(Address)

Katherine Ott
1106 William

15

Filed

19

NOV 1-1922 ROBERT R. KRAUTER Registrar

Bacial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 13 1922 to Oct 29 1922

that I last saw her alive on Oct 29 1922

and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular
heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Wm. Butler

M. D.

1930 Address

1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathlamet Cemetery

Nov 2 1922

20 UNDERTAKER

ADDRESS

F.A. Krause & Son

723 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68816

D 68816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5112 Harford Road ST. 27 WARD)

2-FULL NAME

Theodore Schardt

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO.

5112 Harford Road ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 17-1882

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

40512

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Michael Schardt

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Henrietta Eickel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Margaret Schardt
5112 Harford Road

15

File

NOV 1-1922 ROBERT R. KRAUSE

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1, 1919, to Oct 29, 1922
that I last saw him alive on Oct 29, 1922and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary TuberculosisCONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(duration) 3 yrs. mos. ds.18 Where was disease contracted if not at place of death? Place of deathDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Sputum(Signed) Henry A. King M. D.1922 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Parkwood Cem

20 UNDERTAKER

F.A. Krause & Son

DATE OF BURIAL

Nov 2 1922

ADDRESS

703 Haven

Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68817

D 68817

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Mildred Harris or Harrid(a) RESIDENCE NO. 1012 Carlton st.
(Usual place of abode)ST. 16 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 19077 AGE Years Months Days If LESS than 1 day, hrs. or min.
15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employee:

9 BIRTHPLACE (city or town)
(State or country)Maryland10 NAME OF FATHER Dennis Harrid11 BIRTHPLACE OF FATHER (city or town)
(State or country)Maryland12 MAIDEN NAME OF MOTHER Susie Honey13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Maryland14 Informant Hospital Records
(Address) H. T. H.15 Filed Nov 1-1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 30, 192217 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 19 22, to Oct. 30, 19 22.that I last saw her alive on Oct. 30, 19 22.and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of intestines(duration) yrs. 4-5 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date ofWas there an autopsy? yesWhat test confirmed diagnosis? autopsy
(Signed) J. A. McKay, M. D.10-30-22 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

10-30-22 Mr. Auburn Nov 2 1922
20 UNDERTAKER ADDRESS 142John H. Toadwin urkell

maison should be carefully supervised. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 68818

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2217 Booth St. 70 Ward)

Registered No. C.....

2-FULL NAME.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2217 Booth St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

NOV 1 - 1922

Baltimore Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER,

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68819

CERTIFICATE OF DEATH.

V 47 D 68819

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2445 Barclay ST.;

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2445 Barclay St.;

yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan 25, 1922
(Month) (Day) (Year)

7-AGE, 65 yrs., 6 mos., 6 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Buena Vista

10-NAME OF FATHER, Louis W. Klump

11-BIRTHPLACE OF FATHER (State or Country), Penn.

12-MAIDEN NAME OF MOTHER Laura B. Fox

13-BIRTHPLACE OF MOTHER (State or Country), Penn.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Klump

(Address) 2445 Barclay St.

15- NOV 1-1922 ROBERT R. KRAUTER

Filed NOV 1-1922 Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Oct 30, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 10, 1921, to Oct 30, 1922, that I saw her alive on Oct 30, 1922, and that death occurred, on the date stated above, at 7:30 P. m. The CAUSE OF DEATH* was as follows:

Exhaustion
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast
(Duration) yrs. mos. ds.

(Signed) L. A. Richardson M. D.
Oct 31, 1922 Address 11211 35th St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Madison Park DATE OF BURIAL, 11/1/22

20-UNDERTAKER Adrian M. Walker ADDRESS 737 N. Lafayette

CAUSE OF DEATH in plain terms, as that it may be properly important. See instructions on back of certificate.

D 68820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68820

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 236 S. Duncan ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Louise Pitt

(a) RESIDENCE NO.

236 S. Duncan ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Louis Pitt

6 DATE OF BIRTH (month, day, and year)

March 6, 1845

7 AGE

77

Years

Months

7

Days

23

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Bornhof

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14

Informant (Address)

Louis P. Druschel
236 S. Duncan St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct 26, 1922, to Oct 28, 1922.that I last saw her alive on Oct 28, 1922.and that death occurred, on the date stated above, at 12¹⁰ A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed)

John F. O'Connell, M. D.

(Address)

35 N. Potomac St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Gen

DATE OF BURIAL

Nov. 1 1922

20 UNDERTAKER

H. Sander Son

ADDRESS

1712 N. 2nd St.

Exact statement of OCCUPATION should be carefully supplied. Information should be given in plain terms, so that it may be properly classified. See instructions on back of certificate. CAUSE OF DEATH is very important.

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68821

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 332 S. Robinson ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Marie Hammer

(a) RESIDENCE NO.

332 S. Robinson ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

Joseph J. Hammer

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 2, 1900

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

211128

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

William F. Inwall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Catherine Nelson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

Joseph J. Hammer 332 S. Robinson St.

15

Filed

1922

Burlat Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

June 10 - 1922 to Oct. 30 1922that I last saw her alive on " 27 1922and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? At homeDid an operation precede death? No Date of "Was there an autopsy? NoWhat test confirmed diagnosis? Physical signs(Signed) Chas. B. Neer, M. D.Address) 4085 Pat PK Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

MOVAL

Oak Lawn Cem.

DATE OF BURIAL

Nov 2 1922

20 UNDERTAKER

The Sander Sons

ADDRESS

1710 Pk Ave

Information should be carefully supplied. Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 68822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1820 Brewster

ST. 14

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Phyllis Griffith

(a) RESIDENCE. No. 1820 Brewster

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

A

4 COLOR OR RACE

OK.

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

June 4 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

James Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

James Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

James Griffith 1820 Brewster

15

Filed

19

ROBERT R. REASTER

Registrar

Baltimore Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 30 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 23 1922, to Oct 30 1922.

that I last saw him alive on Oct 30 1922.

and that death occurred, on the date stated above, at 6:4 m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68823

CERTIFICATE OF DEATH.

D 68823

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *405 N. Chapple* ST., *6* WARD)2. FULL NAME *William J. Crow*(a) RESIDENCE NO. *405 N. Chapple* ST., _____ WARD _____

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? *Life* yrs. _____ mos. _____ ds. _____

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male**White**Baby*

5a If married, widowed, or divorced HUSBAND of _____ or WIFE of _____

6 DATE OF BIRTH (month, day, and year) *Oct 29 - 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*10 NAME OF FATHER *James S. Crow*11 BIRTHPLACE OF FATHER (city or town) *West Point* (State or country) *Tennessee*12 MAIDEN NAME OF MOTHER *Char Brockschmidt*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country)

14

Informant *James S. Crow* (Address) *405 N. Chapple St.*

15

Filed

19

ROBERT H. KRAUTER, Registrar

Burial Permit _____

MEDICAL CERTIFICATE

16 DATE OF DEATH (month, day, and year) *10-31 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*10-29**1922* to*10-31**1922*

that I last saw him alive on

*10-31**1922*and that death occurred, on the date stated above, at *6:30* m.

The CAUSE OF DEATH* was as follows:

*Premature Birth
Hydromus*

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Intense Endocarditis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death? *unknown*Did an operation precede death? *No*

Date of _____

Was there an autopsy? *No*What test confirmed diagnosis? *findings*(Signed) *W. H. ...**10-31-22*19 (Address) *603 North ...*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Holy Redeemer Chm

20 UNDERTAKER

Mrs. C. Miller

DATE OF BURIAL

Nov 1 1922

ADDRESS

2334 Jeffers

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68824

D 68824

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1508 N Bethel* St.; *8* WARD)

2-FULL NAME

(Residence in Baltimore: No. *1508 N Bethel* St.; *75* yrs., *9* mos., *21* ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

*White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) *Widower*

6-DATE OF BIRTH

JAN 9, 1847

(Month)

(Day)

(Year)

7-AGE

75 yrs., 9 mos., 21 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Sheet metal*(b) General nature of industry, business, or establishment in which employed (or employer). *worker*9-BIRTHPLACE, (State or Country), *Baltimore Md*10-NAME OF FATHER, *Not known*11-BIRTHPLACE OF FATHER (State or Country), *Not known*12-MAIDEN NAME OF MOTHER *Not known*13-BIRTHPLACE OF MOTHER (State or Country), *Not known*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Walter C. Magers*(Address) *1508 N. Bethel St.*

15-

Filed

*NOV 1-1922**ROBERT R. KRAUTER,**Burial Permit*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

October 30, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

APR 30 1922 191, to *OCT 30 1922* 191that I saw him alive on *OCT 30 1922* 191and that death occurred, on the date stated above, at *7 P* m.

The CAUSE OF DEATH* was as follows:

Cornal abrasion about 4 hours duration(Duration) *18 yrs., 7 mos., 7 ds.*CONTRIBUTORY, *Diabetes mellitus*(Secondary) (Duration) *10 yrs., 7 mos., 7 ds.*(Signed) *W. H. Becker, M. D.**OCT 30 1922* (Address) *928 N. North St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *75 yrs., 9 mos., 21 ds.* In the State *75 yrs., 9 mos., 21 ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

London Park Cemetery

DATE OF BURIAL

Nov. 2, 1922

20-UNDERTAKER

Henry Lutz

ADDRESS

1203 N. Broadway

CAUSE OF DEATH in plain terms, as far as it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68826

D 68826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *St. Vincent's Infant Asylum*CITY OF BALTIMORE: (No. *14* ST., *14* WARD)2-FULL NAME *Margaret Mary Mc Dermott*(a) RESIDENCE NO. *1401 Division St.* ST., *14* WARD(Usual place of abode)
Length of residence in city or town where death occurred

yrs.

mos.

19 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Female**White*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Oct 11, 1922*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*19*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore, Md.*
(State or country)10 NAME OF FATHER *John Spencebank*11 BIRTHPLACE OF FATHER (city or town) *Baltimore, Md.*
(State or country)12 MAIDEN NAME OF MOTHER *Mary E. M. Dermott*13 BIRTHPLACE OF MOTHER (city or town) *Baltimore, Md.*
(State or country)14 Informant *St. Vincent's Inf Asylum*
(Address)15 *NOV 1-1922* *ROBERT R. KRAUTER,*
Filed *19* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 30, 1922*

17

I HEREBY CERTIFY, That I attended deceased from
*Oct 11, 1922, to Oct 30, 1922,*that I last saw her alive on *Oct. 29th, 1922,*and that death occurred, on the date stated above, at *10 A. m.*

The CAUSE OF DEATH* was as follows:

Infantile

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *No* Date of *Oct 30/22*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Robert R. Krauter* M. D., 19 (Address) *1401 Division St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOV

DATE OF BURIAL

St. Patrick's Cem - Nov 1, 22

20 UNDERTAKER

ADDRESS

Mrs. Mrs. N. J. Pink 1737 N. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68827

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68827

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. *WARD*)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

A.

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown 1872

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

50 yrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Not any

9 BIRTHPLACE (city or town) (State or country)

Balto. Md

10 NAME OF FATHER

Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

"

12 MAIDEN NAME OF MOTHER

"

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

"

14

Informant (Address)

Joseph. Harper

15

Filed

NOV 7 - 1922

ROBERT R. KRAUER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10-30* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *P. 25*, 19 *22*, to *10-30*, 19 *22*.that I last saw him alive on *10-30*, 19 *22*.and that death occurred, on the date stated above, at *9:30 p.m.*

The CAUSE OF DEATH* was as follows:

*Hydrocephalus - Chr. Nephritis -**many yrs* (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *W. C. Caldwell*, M. D., 19 (Address) *St. Agnes Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Catholic Cem
Martin Frederickson 1827 W. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68828

CERTIFICATE OF DEATH.

122-001 D 68828

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 Russell St ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Otto R. Tribull

(a) RESIDENCE NO.

1025 Russell

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMargaret Tribull6 DATE OF BIRTH (month, day, and year) April 4 1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.65626

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

City Dept

(b) General nature of industry, business, or establishment in which employed (or employer)

Paving

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Germany

10 NAME OF FATHER

Friedrich Tribull

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Caroline Tribull

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)Margaret Tribull wife
1025 Russell St

15

Filed

19

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 29 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 18 1922 to Oct 29 1922that I last saw him alive on Oct 29 1922and that death occurred, on the date stated above, at 11:55 P. m.

The CAUSE OF DEATH* was as follows:

Perforation of Liver

(duration)

yrs. 6mos. 9

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs. 4mos. 14

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

exam(Signed) John C. Smith, M. D.19. 1922 (Address) 517 Lewis St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

Nov. 1 1922

20 UNDERTAKER

James Dignam & Son

ADDRESS

1600 S. PacastExact statement of OCCURRENCE
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68829

D 68829

CERTIFICATE OF DEATH. 65-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3810 *Lorchester Road* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louis Bernstein

(a) RESIDENCE No.

3810 Lorchester Road

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

3

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Fannie Bernstein*

6 DATE OF BIRTH (month, day, and year)

Nov. 15, 1882

7 AGE

Years

Months

Days

If LESS than
1 day, ... hrs.
or min.*39**11**16*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Rabbi.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Omaha, Neb.*

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant
(Address)*Mr. Chas. Weiler
3810 Lorchester Road*

15

NOV 1-1922

ROBERT R. KRAUTER,

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/31/1922*

17

I HEREBY CERTIFY, That I attended deceased from
*Nov. 15, 1920, to Oct. 31st, 1922*that I last saw him alive on *Oct 31st, 1922*and that death occurred, on the date stated above, at *6:10 A. M.*

The CAUSE OF DEATH* was as follows:

Hodgkins Disease(duration) *2* yrs. mos. ds.CONTRIBUTORY
(Secondary)*Cardiac Dilatation*(duration) yrs. mos. ds. *1* ds.

18 Where was disease contracted

if not at place of death?

not known

Did an operation precede death?

No

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Gland removed & examined microscopically

(Signed)

M. D.

, 19

(Address)

Ph. & Lafayette Aves.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Landon Park Crematory**11/3/1922*

20 UNDERTAKER

David Sondheim

ADDRESS

118 W. Mt. Royal Ave.

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68830

CERTIFICATE OF DEATH.

D 68830

1-PLACE OF DEATH

City of BALTIMORE: (No. *1112 N. Stockton* St. *16* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1112 N. Stockton St* St.; yrs.,..... mos. *13* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-Single,
Married,
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH,

October 17 19*22*
(Month) (Day) (Year)

7-AGE,

If LESS than 1 day,

yrs. mos. *13* ds.

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
-
- (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country).10-NAME OF
FATHER,11-BIRTHPLACE
OF FATHER,
(State or Country),12-MAIDEN NAME
OF MOTHER,13-BIRTHPLACE
OF MOTHER,
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

NOV 1 - 1922

ROBERT H. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct. 30 19*22*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an.....
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to..... death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis
(Duration) yrs. mos. *2* ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. T. Hennessy* M. D.(Coroner) *Nov. 1, 1922* (Address) *2802 Edgewood*

*State the Disease Causing Death, or, in deaths from Violent Cause, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*St Auburn**11/4/22* 19....

20-UNDERTAKER,

ADDRESS

*Sam R. Chase**1460 N. Howard St*

State CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Woman's Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Lafayette & Johns

ST.,

WARD)

2-FULL NAME

Howard Hardin.

(a) RESIDENCE NO.

426 W. Mulberry

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Hubert Hardin

11 BIRTHPLACE OF FATHER (city or town)

Brevard

(State or country)

North Carolina

12 MAIDEN NAME OF MOTHER

Maud Brown

13 BIRTHPLACE OF MOTHER (city or town)

Atlanta

(State or country)

Georgia

14

Informant

(Address)

Mrs C.C. Ferguson

426 W. Mulberry St.

15

Filed

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 1 1922

17

I HEREBY CERTIFY, That I attended deceased from 10-30, 1922, to 10-31, 1922,

that I last saw him alive on 10-31-22, 19

and that death occurred, on the date stated above at 12:45 P. M.

The CAUSE OF DEATH* was as follows:

Intra cranial hemorrhage

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

clinical findings

(Signed)

G. F. Goff

M. D.

19

(Address)

Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Burial

DATE OF BURIAL

Nov 1 1922

20 UNDERTAKER

St. John's Hospital

ADDRESS

1500 W. Lombard

D 68833 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D 68833

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 N. Truex ST. WARD)

REGISTERED NO.
(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

(a) RESIDENCE NO. 614 N. Truex ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 1/2 mos. • How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed,
or Divorced, (write the word) Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 9, 1850

7 AGE Years Months Days If LESS than
1 day, hrs. or min.
72 7 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

NOV 1 - 1922

ROBERT W. KRATZER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct 20, 1922, to Oct. 30, 1922.

that I last saw him alive on Oct. 30, 1922.

and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

10.31.1922 (Address) 1201 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. Exact statement of OCCASION
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

B 68834

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002 D 68834
REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Jesse Plaine(a) RESIDENCE NO. 1523 Light St., City ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Emma Plaine6 DATE OF BIRTH (month, day, and year) May 4 - 18487 AGE Years 74 Months 5 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland10 NAME OF FATHER Stephen Plaine

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Maryland12 MAIDEN NAME OF MOTHER Nancy Sponseller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Maryland

14

Informant JOHNS HOPKINS HOSPITAL (Address)

15

Filed

19

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1922

17

I HEREBY CERTIFY, That I attended deceased from July 27, 1922, to Oct. 31, 1922, that I last saw him alive on Oct. 31, 1922, and that death occurred, on the date stated above, at 1 53 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction, complete(duration) yrs. mos. 2 ds.CONTRIBUTORY Pulmonary edema. (Secondary)(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Oct 10, '22

Was there an autopsy?

What test confirmed diagnosis? autopsy(Signed) J. L. Houghton, M. D.19 (Address) Johns Hopkins Hospital

*State the Disease causing Death, or in deaths from violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

NOVAL
London Pk Cem

DATE OF BURIAL

11 1922

20 UNDERTAKER

J. Faw Mc Gully

ADDRESS

130 E. Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D 68835

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68835

CERTIFICATE OF DEATH. 784

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mabel Hendricks

(a) RESIDENCE NO.

R#1 Chinagrove, N.C. ST. 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21-19137 AGE Years 9 Months 3 Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

N.C.

10 NAME OF FATHER

John Hendricks

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N.C.

12 MAIDEN NAME OF MOTHER

Sarah Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N.C.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31-1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 27, 1922, to Oct 31, 1922that I last saw her alive on Oct 31, 1922and that death occurred, on the date stated above, at 3:50 p.m.

The CAUSE OF DEATH* was as follows:

Brain tumor - glioma cyst cerebellar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

Yes Date of Oct. 31

Was there an autopsy?

Yes

What test confirmed diagnosis?

Operation

(Signed)

J. H. Hendricks M. D.

, 19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Chinagrove N.C.

DATE OF BURIAL

11/1/22

20 UNDERTAKER

W. H. Hughes 444 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Burial Permit Blank.

D 68836

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68836

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. VETERANS' HOSPITAL #56,

CITY OF BALTIMORE: (No. FORT MC HENRY, MD. ST. 24 WARD) 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME RENN, Everett C.

(a) RESIDENCE NO. Williamson, W.Va.
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. -- mos. -- ds. -- How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds. --

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) --

7 AGE 27 Years Months Days If LESS than 1 day, hrs. or min. --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer --

9 BIRTHPLACE (city or town) Va. (State or country) --

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14

Hospital Records (Address) Fort McHenry, Md.

15

Robert P. Harrison, Registrar

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1922

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1922, to Oct. 31, 1922.

that I last saw him alive on Oct. 31, 1922,

and that death occurred, on the date stated above, at 10.20 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, chronic, Far Advanced, Active.

(duration) Unknown yrs. -- mos. -- ds.

CONTRIBUTORY Empyema (Secondary)

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? T.B. Bac.

(Signed)

J. B. Harrison

M. D.

10/31 1922 Address) Fort McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Williamson W. Va.

20 UNDERTAKER

S. Harrison & Bro

DATE OF BURIAL

11/1 1922

ADDRESS 1127

E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D 68837

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68837

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6011 Ready Ave. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

George Frederick Bouldin

(a) RESIDENCE NO.

6011 Ready Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Mollie E. Bouldin

6 DATE OF BIRTH (month, day, and year)

Apr. 6th 1867

7 AGE

Years

Months

Days

If LESS than
1 day.....hrs.
or min.

55

6

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Clerk

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

Md.

10 NAME OF FATHER

George Henry Bouldin

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Baltimore

Md.

12 MAIDEN NAME OF MOTHER

Margaret E. Jenkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Baltimore

Md.

14

Informant
(Address)Mary E. Bouldin
6011 Ready Ave.

15

Filed

19

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31st 19 22

17

I HEREBY CERTIFY, That I attended deceased from
Jan. 1902, to Oct. 31, 1922,
that I last saw him alive on Oct. 31, 1922,

and that death occurred, on the date stated above, at 8.15 A.M.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) 20 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Chemic

(Signed)

H. C. Hoen

M. D.

10/31/22 address) 5600 York Road

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

London Park Cem

Nov. 3rd 22

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1002 N. Baltimore

D 68838

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68838

1-PLACE OF DEATH

City of BALTIMORE: (No. *101* St. *4* Ward)

2-FULL NAME

(Residence in Baltimore: No. *—* St.; yrs. *—* mos. *—* ds.)

CERTIFICATE OF DEATH

Registered No. C. *101*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced *Single*
(Write the word.)

6-DATE OF BIRTH. (Month) (Day) (Year)

7-AGE. *36* yrs. *—* mos. *—* ds. If LESS than 1 day, hrs. or min. *—*8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *Patent Valves*
(b) General nature of industry, business, or establishment in which employed (or employer) *Patent Valves*9-BIRTHPLACE (State or Country) *N.Y.*10-NAME OF FATHER *Patent*11-BIRTHPLACE OF FATHER (State or Country) *Patent*12-MAIDEN NAME OF MOTHER *K. W. V.*13-BIRTHPLACE OF MOTHER (State or Country) *K. W. V.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

Robert P. Harrison,

192

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Oct 31* 192*2*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquest* (Inquest, au-

topsy or inquiry.) And that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent Valves
Acute Cardiac Dilatation
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) *W. J. G. G. G.* M. D.
(Coroner)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Washington DC**Nov. 1* 19 *22*

20-UNDERTAKER

ADDRESS

*Harry A. Witzke**1531 W. Lombard St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68839

CERTIFICATE OF DEATH.

188-002
D 68839

PLACE OF DEATH

CITY OF BALTIMORE (No. *St Josephs Hospital* ST. 92-FULL NAME *Amos Cranston*(Residence in Baltimore: No. *York Road & Suburban* St.; yrs., mos. da.)

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-SINGLE *Married*
 MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
 6-DATE OF BIRTH, *Sept 27, 1870*
 (Month) (Day) (Year)

7-AGE, *50* yrs. *1* mos. *3* da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
 (a) Trade, profession, or particular kind of work *Carpenter*
 (b) General nature of industry, business, or establishment in which employed (or employer) *012*

9-BIRTHPLACE, (State or Country), *Balto Md*

10-NAME OF FATHER, *Wm A. Cranston*

11-BIRTHPLACE OF FATHER (State or Country), *Balto Md*

12-MAIDEN NAME OF MOTHER *Anna B Amos*

13-BIRTHPLACE OF MOTHER (State or Country), *Harford Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *M. Sallie Hoffman*

(Address) *2321 Calver Ave*

15- *Robert P. Harrison*
 Filled *101*

1-1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 31, 191...*
 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry*
 (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, au-
 topsy or inquiry.) and that said deceased came to *death*
 on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Base of Skull
Struck by street car
Investigation & Report Nov 2nd 1911
 (Duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... da.
 (Signed) *J. H. ...* M. D.
 (Coroner.)
 11-1-1082 (Address) *502 E North*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place In the
 of death ... yrs. ... mos. ... da. State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Presbyterian Church* DATE OF BURIAL, *Nov 2nd, 1911*

20-UNDERTAKER *William Cook* ADDRESS *502 E North*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION if very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68840

D 68840

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. *Little Sister of Mr. Post* 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Hopkins*(a) RESIDENCE NO. *Princeton Valley Ho.* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds. How long in U. S., if of foreign birth? *50* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow of*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Michael Hopkins*

6 DATE OF BIRTH (month, day, and year)

7 AGE *Unknown* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Patrick Finn*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Anna Flanagan*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Anna Ackman* (Address) *2505 Allen Ave.*15 Filed *Robert P. Harrison* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 31 1922*17 I HEREBY CERTIFY, That I attended deceased from *No record* 19 to 19that I last saw him alive on *Oct 29* 1922and that death occurred, on the date stated above, at *12.30 P.M.*

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. J. Warner* M. D.1922 (Address) *1133 Valley St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Nov 2 1922

20 UNDERTAKER ADDRESS

H. C. Windefield, 900 Green St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

(Annie L Bond) ✓
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68841

CERTIFICATE OF DEATH.

REGISTERED NO.

68841

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

ds.

How long in U. S., if of foreign birth?

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than

24 hrs. day, hrs.

or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 30 a.m. 1922, to Oct 30 P.M. 1922,

that I last saw her alive on Oct 30, 1922,

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulver Pneumonia preceded by heavy cold for 2 weeks

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) J. Burnett Flago, M. D.

19 (Address) 746 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

1-1922

Burial Permit Clerk.

David Easton

Deane

D 68842

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68842

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Park av ST., 10 WARD)

2-FULL NAME

Winters Brown

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1001 Park av ST., 10 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE col. 5 Single, Married, Widowed, or Divorced, (write the word) married5a If married, widowed, or divorced HUSBAND of alice brown (or) WIFE of6 DATE OF BIRTH (month, day, and year) 1893-7-47 AGE 29 Years 3 Months 25 Days If LESS than 1 day, 0 hrs. or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Samuel Ward9 BIRTHPLACE (city or town) (State or country) City10 NAME OF FATHER Jas. H. Brown11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.12 MAIDEN NAME OF MOTHER alice brown13 BIRTHPLACE OF MOTHER (city or town) (State or country) W.D.14 Informant alice E. Brown mother (Address) 1138 Park av15 Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/29/192217 I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1922 to Oct. 29, 1922that I last saw him alive on Oct. 29, 1922and that death occurred, on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

UremiaCONTRIBUTORY (Secondary) acute nephritis (duration) 3 yrs. 0 mos. 0 ds.18 Where was disease contracted if not at place of death? nowDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physical (Signed) John H. Thompson, M. D.(Address) 1019 N. Lincoln St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL St. Auburn Cem

20 UNDERTAKER

Daniel Carter

DATE OF BURIAL

Nov 2, 1922

ADDRESS

986 Pa av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement in OCCASION is very important. See instructions on back of certificates.

1-1922

Burial Permit 41033

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g. *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Alcoholism

(Wilson)
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68843

CERTIFICATE OF DEATH.

D 68843

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23-N-Bruce St

ST., 19 WARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30 1922

17

I HEREBY CERTIFY, That I attended deceased from
10-28, 1922, to 10-30, 1922

that I last saw him alive on 10-30, 1922.

and that death occurred, on the date stated above, at 5:20 AM

The CAUSE OF DEATH* was as follows:

Is for pneumonia
Bilateral

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. J. Harrison, M. D.

, 19 (Address) 1980 - muller

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

 CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

1-1922

Burial Permit Clerk

D 68844 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68844

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 145 W. Montgomery St. St. 22nd Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Anderson Stark.(C).....

(Residence in Baltimore: No. 145 W. Montgomery St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male. 4-COLOR OR RACE, Colored. 5-Single, Married, Widowed, or Divorced, Single. (Write the word.)

6-DATE OF BIRTH, January 6, 1905. (Month) (Day) (Year)

7-AGE, 17 yrs. 9 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Laborer. (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Virginia.

10-NAME OF FATHER, Hanson Stark.(C).

11-BIRTHPLACE OF FATHER, (State or Country), Virginia.

12-MAIDEN NAME OF MOTHER, Elizabeth Hays.(C).

13-BIRTHPLACE OF MOTHER, (State or Country), Virginia.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Stark.(C)(mother)

(Address) 145 W. Montgomery Street.

15- Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 30, 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.)

thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

CONTRIBUTORY (Secondary)

(Signed) Otto M. Reinhardt, M.D. (Coroner)

Oct. 30, 1922. (Address) 1017 S. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death? Virginia.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn Ct Nov 2, 1922

20-UNDERTAKER, ADDRESS

J. H. Brown & Son 108 W. Montz St.

D 68845

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2688 Wilkins Ave. St. 70 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2688 Wilkins Ave. St. 70 yrs. 2 mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Widow

6-DATE OF BIRTH.

May 15, 1853
(Month) (Day) (Year)

7-AGE,

69 yrs. 5 mos. 11 ds.If LESS than 1 day.
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country),
Carroll County Md

PARENTS.

10-NAME OF FATHER,

John W. Lucabough11-BIRTHPLACE OF FATHER
(State or Country),Md

12-MAIDEN NAME OF MOTHER

Barbara Shaffer13-BIRTHPLACE OF MOTHER
(State or Country),Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Schaffer(Address) 2688 Wilkins Ave.

15-

Filed

Robert F. Harrison,

191

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Oct 30, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 13 1922, to Oct 30 1922,that I saw him alive on Oct 30 1922,and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Heart disease(Duration) 15 yrs. 5 mos. 11 ds.CONTRIBUTORY
(Secondary)(Duration) 15 yrs. 5 mos. 11 ds.(Signed) Frederick J. Smith M. D.Oct 31, 1922 (Address) 2516 Penn. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 15 yrs. 5 mos. 11 ds. In the State 15 yrs. 5 mos. 11 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Westminster Md

DATE OF BURIAL

Nov 2, 1922

20-UNDERTAKER

Wm. J. Pickner & Sons

ADDRESS

111 Pa

important. See instructions on back of certificate.

D 68846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph's Hosp* St. *1* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *2217 Winterset Court* St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*6-DATE OF BIRTH, *Oct 16*, 19*19* (Month) (Day) (Year)7-AGE, *3* yrs.,.....mos. *15* ds. If LESS than 1 day,hrs. or.....min.?8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Chin* (b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), *Balto m*10-NAME OF FATHER, *Frank Priell*11-BIRTHPLACE OF FATHER, (State or Country), *Balto m*12-MAIDEN NAME OF MOTHER, *Rose Banach*13-BIRTHPLACE OF MOTHER, (State or Country), *Balto m*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Frank Priell*(Address) *2217 Winterset Ct*15- *Robert F. Harrison,*Filed, 19*22* Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 31*, 19*22* (Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Burns - Ambrosy
49 cubic surface of body
(chest was playing with matches)
in - dress (inflammation) on face mos.....ds.

CONTRIBUTORY (Secondary)

(Signed) *J. S. H. Oller* M. D. (Coroner.)*11-1* 19*22* (Address) *506 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Rosary *Nov 2*, 19*22*

20-EMERALD, ADDRESS

John M. Weber *1803 Bank*

State CAUSE OF DEATH in plain terms, so that it may be properly is very important. See instructions on back of certificate.

D 68847

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68847

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 E Heath ST., 23 WARD)

2-FULL NAME

Marie M. Winkler

(a) RESIDENCE NO.

29 E Heath

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 8-1907

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20 7 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Maid Servant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Henry P. Winkler

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ind

12 MAIDEN NAME OF MOTHER

Annie Helman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Austria

14

Informant (Address)

Edith Helman 1412 Potomac

15

Filed

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 31 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Mar 1, 19 22, to Oct 30, 19 22

that I last saw her alive on Oct 29, 19 22

and that death occurred, on the date stated above, at 5:15 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration)

yrs.

9 mos

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. H. Harrison, M. D.

19

(Address) 3100 Hartford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Margaret J. Flynn

1422 Light

D 68848

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68848

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 633 Sterling ST. 5 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Escu Richardson(Residence in Baltimore: No. 633 Sterling St.; 44 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

M

4-COLOR OR RACE,

C5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

unknown, 1878.
(Month) (Day) (Year)

7-AGE,

44 yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Laborer

9-BIRTHPLACE, (State or Country),

Baths Md.

10-NAME OF FATHER,

Robert Richardson

11-BIRTHPLACE OF FATHER (State or Country),

Md.

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER (State or Country),

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Richard Gross(Address) 1405 McElberry St

15-

Filed NOV 2-1922 191. ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

10 / 31, 1922.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct 27 1922 to Oct 31 1922that I saw him alive on Oct 30 1922and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac debilitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) mitral insufficiency

(Duration) yrs. mos. ds.

(Signed) R. J. Young M. D.10/31, 1922 (Address) 414 E. Washington

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

LourivalNov. 2, 1922

20-UNDERTAKER

ADDRESS

R. J. Gross 1405 McElberry St

important. See instructions on back of certificate.

D 68849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *635 N. Calhoun* ST. *16* WARD)

2-FULL NAME

Herman H. Kooke

(a) RESIDENCE. NO.

635 N. Calhoun ST. *16* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *74* yrs. *6* mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

July 8-1848

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*74**3**23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

John H. K. Kooke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Amelia C. W. Gude

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

G. F. Kooke 635 N. Calhoun St

15

Filed

*NOV 2 - 1922 ROBERT R. KRAUTER Registrar**Burial Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 31 1922*

17

HEREBY CERTIFY, That I attended deceased from

*Oct 26 1922 to Oct 31 1922*that I last saw him alive on *Oct 31 1922*and that death occurred, on the date stated above, at *8.00 P. M.*

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Arterio-Sclerosis

CONTRIBUTORY (Secondary)

*about 4 yrs. mos. ds.**Thrombosis* (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Permon H. Condon* M. D., 19 (Address) *750 N. North Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Care Oct 3 1922

20 UNDERTAKER

ADDRESS

Chas. E. Branch 807 Madison

D 68850

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68850

CERTIFICATE OF DEATH.

Registered No. C.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2132 Herbert St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 2132 Herbert St. 15 Ward)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH

June 24 1920

7-AGE

2 yrs. 7 mos. 7 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

Baltimore

10-NAME OF FATHER

Charles H. Collett

11-BIRTHPLACE OF FATHER, (State or Country).

Balt. Co.

12-MAIDEN NAME OF MOTHER

Hilda S. Collett

13-BIRTHPLACE OF MOTHER, (State or Country).

Balt.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles H. Collett

(Address)

2132 Herbert St.

NOV 2-1922

ROBERT R. KRAUTER,

Filed

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

October 31 1922

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

first & second degree burns of body.

(Duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

accidental fall

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy

(Coroner.)

No. 14 1922 (Address) 2802 Edmonson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Wood Lawn

DATE OF BURIAL

Nov 2 1922

ADDRESS

A. T. S. Mc

20-UNDERTAKER

H. M. Carter

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

068851 HEALTH DEPARTMENT—CITY OF BALTIMORE 068851
D 68852

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 430 E. Lanvale St. St. 11185 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... J. Henry Grote.

(Residence in Baltimore: No. 430 E. Lanvale St. St.; yrs. 81 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widower, or Divorced, (Write the word.)
Male White.

6-DATE OF BIRTH.
November 1st, 1840. 1.
(Month) (Day) (Year)

7-AGE, 81 yrs. 11 mos. 30 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Locksmith.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.
10-NAME OF FATHER, John Grote.
11-BIRTHPLACE OF FATHER, (State or Country). Germany.
12-MAIDEN NAME OF MOTHER, Do not know.
13-BIRTHPLACE OF MOTHER, (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frederick W. A. Grote (son)

(Address) 430 E. Lanvale St.

15- ROBERT R. KRAUTER,

NOV 2 - 1922 192 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, October 21st, 1922. 192.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry & autopsy (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Extar and sub dural hemorrhage of the brain. Accidental fall down stairs.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) Otto M. Reinhardt (Coroner.)

11/2/22 192 (Address) 0.17 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Loudin Park Nov 2, 1922

20-UNDERTAKER, ADDRESS

East L. Ave., 1439 E. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68852

CERTIFICATE OF DEATH.

75-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

816 Woodley

ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mrs Ida L. Jones

(a) RESIDENCE NO.

816 Woodley

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

Wht

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Jacob A. Jones

6 DATE OF BIRTH (month, day, and year)

May 25th 1876

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

46

5

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Carnall Co Md.

10 NAME OF FATHER

Jacob R. Shamer

11 BIRTHPLACE OF FATHER (city or town)

Ger.

(State or country)

Carnall Co Md.

12 MAIDEN NAME OF MOTHER

Hesterne Youngling

13 BIRTHPLACE OF MOTHER (city or town)

Carnall Co Md.

(State or country)

14

Informant

(Address)

Jacob Jones
816 Woodley St

15

Filed

NOV 2, 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 1st 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug. 28, 1922, to Nov 1st, 1922,that I last saw him alive on Nov 1st, 1922,

and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis, due to inability
to take nourishment
following 2nd paralytic
strokeCONTRIBUTORY
(Secondary)Paralysis
(duration) yrs. 15 mos. ds.

18 Where was disease contracted

if not at place of death?

Quid.

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Vis. acc

(Signed)

M. D.

1922 (Address) 165 N. North St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Marys Hampden Nov 3 1922

20 UNDERTAKER

ADDRESS

Chenoweth Long Chestnut

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68853

CERTIFICATE OF DEATH.

47 ✓ D 68853

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin St. Hospital ST., 19 WARD)2-FULL NAME Laura M. Cole(a) RESIDENCE NO. Reisterstown R.F.D. md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

(or) WIFE of John Cole6 DATE OF BIRTH (month, day, and year) Oct 28 18647 AGE Years 58 Months 3 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. Md (State or country)10 NAME OF FATHER William C. Cole11 BIRTHPLACE OF FATHER (city or town) Balto Co. Md (State or country)12 MAIDEN NAME OF MOTHER Katherine Wilhelms13 BIRTHPLACE OF MOTHER (city or town) Balto Co (State or country)14 Informant John Cole (Address) Balto Co. Md15 Filed NOV 2 - 1922 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1-1922

17

I HEREBY CERTIFY, That I attended deceased from

10/31-, 1922, to 11-1-, 1922,that I last saw her alive on 11-1-, 1922,and that death occurred, on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast
with metastasis(duration) 2.5 yrs. from mos. 1 ds.CONTRIBUTORY (Secondary) retard(duration) yrs. mos. 2 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert R. Krauter, M. D.11/1/1922 (Address) Franklin St. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-
MOVAL Zion Church, Balto Co. Md DATE OF BURIAL Nov 3 192220 UNDERTAKER W.C. Brooks Sparks Md ADDRESS

Information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 68854

HEALTH DEPARTMENT - CITY OF BALTIMORE

D 68854

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Helen Harrison

(a) RESIDENCE. NO.

Elcheater, Maryland.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1909

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland.

10 NAME OF FATHER

Joseph Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Olivia Pepper

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

Hospital Records

15

Filed

NOV 2 - 1922

ROBERT R. KRAUTER, Registrar

Bucal Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 2* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 2, 19*22*, to *Nov. 2*, 19*22*.that I last saw her alive on *Nov. 2*, 19*22*.and that death occurred, on the date stated above, at *4 A.* m.

The CAUSE OF DEATH* was as follows:

Acute Oedema of the Glottis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Cellulitis of neck.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *Nov. 2, 1922*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

Wm. J. Fulton

M. D.

, 19

(Address) *University Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. John's Cem. City *Nov. 4* 19 *22*

20 UNDERTAKER

ADDRESS

Boston Sons *Ellicott St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68855

CERTIFICATE OF DEATH.

90 D 68855

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 Brexton Al ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Richard Johnson

(a) RESIDENCE. NO.

119 Brexton Alley

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

C

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WidowedMs. Clara Johnson

6 DATE OF BIRTH (month, day, and year)

1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

65

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Butler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

John H. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Miss Mable Johnson
119 Brexton Street

15

Filed

19

NOV 2-1922ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 29, 19 22, to Nov 1, 19 22.that I last saw him alive on Oct 31, 19 22.and that death occurred, on the date stated above, at 459 A m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Disease(duration) 2 3/4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? urinalysis(Signed) H. S. M. Card M. D., 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Trinity Auburn Cmty11-4 19 22

20 UNDERTAKER

ADDRESS

Grover H. Holland631 Krumpholtz Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

D 68856 HEALTH DEPARTMENT—CITY OF BALTIMORE D 68856

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No

2-FULL NAME

(a) RESIDENCE. No

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

July 1922, to Oct 31, 1922.

that I last saw her alive on Oct 30, 1922.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed)

John H. Hoff, M. D.
11/29/22 Address 1843 W. Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUR-
TION is very important. See instructions on back of certificates.

NOV 2-1922

Burial Permit Check

D 68857 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 McCallough

ST. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1422 McCallough

St.; 39 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH,

June 3, 1897
(Month) (Day) (Year)

7-AGE,

15 yrs. 4 mos. ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Maryland

10-NAME OF FATHER,

Harry Longuet

11-BIRTHPLACE OF FATHER, (State or Country),

MD

12-MAIDEN NAME OF MOTHER

Mary Lewis

13-BIRTHPLACE OF MOTHER, (State or Country),

MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Cook

(Address) 1422 McCallough

15-

Filed NOV 2 1922

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Tuesday Dec 31st, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Dec 31st 1922, to Dec 31st 1922

that I saw him alive on Dec 31st 1922,

and that death occurred, on the date stated above, at 6:00 p.m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous hepatitis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) M. D.

1922 (Address) 607 N. Charles

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt. Auburn

DATE OF BURIAL,

Nov. 3, 1922

20-UNDERTAKER

James H. Hummel

ADDRESS

1363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68858

CERTIFICATE OF DEATH.

141 ✓ D 68858

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

6 N. Calhoun ST., 19

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Marie Hoegl

(a) RESIDENCE NO.

6 N. Calhoun ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

50

yrs.

—

mos.

—

ds.

How long in U. S., if of foreign birth?

50

yrs.

—

mos.

—

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

of the late Frank Hoegl

6 DATE OF BIRTH (month, day, and year)

July 25, 1883

7 AGE

Years

Months

Days

69

3

7

If LESS than 1 day, — hrs or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Yours

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Philip Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Elizabeth Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mr. Geo W. Harrison 904 N. Calhoun St

15

Filed

19

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct - 15, 1922, to Nov 1, 1922.

that I last saw him alive on Oct 31 - 1922

and that death occurred, on the date stated above, at 12:30 p.m.

The CAUSE OF DEATH* was as follows:

Ulcus - cruris - Chronic (infection)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Septic Infection - (duration) 1/2 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? 20 Date of

Was there an autopsy? no

What test confirmed diagnosis? blood

(Signed) M. E. Brucet M. D.

19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt. Carmel Cemetery Nov 4 1922

20 UNDERTAKER

ADDRESS

Joo Janssens & Son 217 S. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

NOV 2-1922

Burial Permit Clerk.

D 68859 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90

D 68859

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1734 E Chase ST., 8 WARD)

2-FULL NAME

Edward A Bacon

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1734 E Chase

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annie B Bacon

6 DATE OF BIRTH (month, day, and year)

Aug 3, 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

2

29

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

James A. Bacon

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Mary A O'Keefe

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant

(Address)

Walter E Bacon
1804 E Lafayette Ave

15

Filed

NOV 2 1922

ROBERT R. KRAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 2 1922, to Oct 31 1922

that I last saw him alive on Oct 31 1922

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 3 yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter H White M. D.

11/1, 1922 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Woodlawn Cem

DATE OF BURIAL

Nov 3 1922

20 UNDERTAKER

Kreemann

ADDRESS

3x St Paul St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68860

D 68860

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007. *Alizanna* ST., *2* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 6 mos.

ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND or (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

NOV 2 1922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 1, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1922, to Nov. 1, 1922,

that I last saw him alive on Oct. 30, 1922, at 5 a. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Chronic nephritis

myocarditis with complete heart block

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

Cardiac decompensation

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed)

Fred A. Reis, M. D.

, 19

(Address)

24 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

tion should be carefully examined, so that it may be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

D 68861 HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68861

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *1612 Gough* St. *2* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1612 Gough* St.; *40* yrs., *40* mos., *40* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Married*6-DATE OF BIRTH, *May 3rd 1841*
(Month) (Day) (Year)7-AGE, *81* yrs., *5* mos., *28* ds. If LESS than 1 day, *hrs.* or *min.*?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work
- Master*
-
- (b) General nature of industry, business, or establishment in which employed (or employer)
- 02*

9-BIRTHPLACE, (State or Country), *Germany*PARENTS.
10-NAME OF FATHER, *Herman Hilgeman*
11-BIRTHPLACE OF FATHER, (State or Country), *Germany*
12-MAIDEN NAME OF MOTHER, *Unknown*
13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. H. Fowler*(Address) *2938 Hudson St*

15-

Filed

NOV 2 - 1922

ROBERT R. KRAUTER,

Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 31st*
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* and that said deceased came to *his death* (topsy or inquiry.) on the day stated above.
The CAUSE OF DEATH* was as follows:*Apoplexy**at once*(Duration) *hrs.* *mos.* *ds.*

CONTRIBUTORY (Secondary)

(Signed) *Thos. B. Norton* M. D.
(Coroner.)*Oct 31st 1922* (Address) *Curtis Bay**State the Disease Causing Death or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal. *Baltimore*

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death *hrs.* *mos.* *ds.* In the State *hrs.* *mos.* *ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Mount Carmel Nov 3, 1922
Lois's Heeman 32 Broad

state CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68862

CERTIFICATE OF DEATH.

90 D 68862

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3808 Calver* St.; *20* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mollie Pearman*(Residence in Baltimore: No. *3808 Calver St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *white* 5-SINGLE, *Married*
(Write the word.)

6-DATE OF BIRTH *May 28, 1873*
(Month) (Day) (Year)

7-AGE *69* yrs. *5* mos. *3* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Retired*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Baltimore*

10-NAME OF FATHER, *Thomas Brooks*

11-BIRTHPLACE OF FATHER (State or Country), *Ireland*

12-MAIDEN NAME OF MOTHER *Don't Know*

13-BIRTHPLACE OF MOTHER (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Lula B. Boecher*(Address) *3808 Calver St.*

15-

Filed *NOV 2-1922* 191. *ROBERT P. KRAUTER* Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH *Oct. 31, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Sept 15, 1922*, to *Oct 31, 1922*, that I saw her alive on *Oct 31, 1922*, and that death occurred, on the date stated above, at *11:10 P* m. The CAUSE OF DEATH* was as follows:

Endocarditis
(Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary) *Pulmonary Disease*

(Signed) *J. B. Culbertson* M. D.
11/1/22, 1922 (Address) *1901 Eutan Pl.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Greenmount Cem* DATE OF BURIAL, *Nov 4th, 1922*

20-UNDERTAKER *A. Jones* ADDRESS *1112 S. Gilman*

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68863

CERTIFICATE OF DEATH.

D 68863

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 S. 4th ST. 26 WARD)

2. FULL NAME

Luisa M. Wilmer

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

705 S. 4th

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

20 yrs.

mos.

17 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND or
(or) WIFE ofMillard M. Wilmer

6 DATE OF BIRTH (month, day, and year)

Oct 14 - 1902

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.20—17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)City

10 NAME OF FATHER

Geo. F. Williams11 BIRTHPLACE OF FATHER (city or town)
(State or country)Md.

12 MAIDEN NAME OF MOTHER

Margaret V. Hagg13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Md.

14

Informant
(Address)Millard M. Wilmer
705 S. 4th St.

15

NOV 2 - 1922

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 31 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1922 to Oct 31, 1922
that I last saw him alive on Oct 31, 1922and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) yrs. 4 mos. 1 ds.CONTRIBUTORY
(Secondary)Acute Edema of Lung
(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted

if not at place of death? unknownDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Findings(Signed) M. J. Hagg, M. D.19 (Address) 800 N. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVALHoly Redeemer

DATE OF BURIAL

Nov 3 1922

20 UNDERTAKER

Philips Henig

ADDRESS

2016 Orleans

D 68864

HEALTH DEPARTMENT—CITY OF BALTIMORE D 68864

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 W. Baltimore ST. 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel William Kammer

(a) RESIDENCE. NO. 1928 W Baltimore ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Anna E. Kammer

6 DATE OF BIRTH (month, day, and year) April 5-1854

7 AGE Years 68 Month 6 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Wm Kammer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Reimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna E. Kammer (Address) 1928 W Baltimore St

15 Filed . 19

ROBERT R. KRAUTER, Registrar

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 30 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 29 1922 to Oct 30 1922 that I last saw him alive on Oct 30 1922

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Dilatation Mucositis

CONTRIBUTORY (Secondary) (duration) 5 yrs. mos. ds. (Cause)

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) E. Miller M. D.

10/31/22 Address 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

J. B. Shipman 2216 Fred L Ave

Information should be carefully supplied. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

NOV 2-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68865

CERTIFICATE OF DEATH.

D 68865

1-PLACE OF DEATH

City of BALTIMORE: No.

2-FULL NAME

(Residence in Baltimore: No.

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs.; mos.; ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single, Married, Widowed, or Divorced. (Write the word.)

Unknown

6-DATE OF BIRTH

Unknown

7-AGE

67

about

If LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Carpenter

9-BIRTHPLACE. (State or Country).

N. J.

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER. (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER.

Unknown

13-BIRTHPLACE OF MOTHER. (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Chas Delpz

(Address)

730 E. Pratt St.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Oct 15

1922

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

Autopsy

thereon and from the evidence obtained by said

Autopsy

find that said deceased came to his death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

Fell down steps

(Signed)

Thos. B. Norton

Oct 17

1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

PUBLIC CEMETERY

20-UNDERTAKER

Commissioner Health

ADDRESS

NOV 2 1922

18-

NOV 2 1922

ROBERT B. KRAUTER,

Registrar.

PER. WM. E. WOODALE

state CAUSE OF DEATH in plain terms, so that it may be properly checked is very important. See instructions on back of certificate.

D 68866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68866

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3907 Pheta M.* ST.: *76* WARD)

REGISTERED No. C

2-FULL NAME

(Residence in Baltimore: No. *3907 Pheta M.* St.: _____ yrs., *5* mos. *16* da.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

Single

6-DATE OF BIRTH,

*May 6**1922*

(Month)

(Day)

(Year)

7-AGE,

5 yrs. *16* mos. *16* da.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Child.

9-BIRTHPLACE, (State or Country),

Baltimore

10-NAME OF FATHER,

John G. Frusky

11-BIRTHPLACE OF FATHER (State or Country),

Baltimore

12-MAIDEN NAME OF MOTHER

Amelia Smith

13-BIRTHPLACE OF MOTHER (State or Country),

Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Amelia Smith*(Address) *3907 Pheta M.*

15-

Filed

NOV 2-1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Nov 1**1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

July 15 1922, to *Nov 1 1922*that I saw *him* alive on *Nov 1 1922*and that death occurred, on the date stated above, at *11 a.* m.

The CAUSE OF DEATH* was as follows:

Exhaustion(Duration) *3* mos. *15* da.

CONTRIBUTORY (Secondary)

Chronic Alcoholism(Signed) *Loius V. ...* M. D.*Nov 1, 1922* (Address) *2608 E. ...*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *...* yrs. *...* mos. *...* da. In the State *...* yrs. *...* mos. *...* da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

St. ...

DATE OF BURIAL,

Nov. 3rd, 1922

20-UNDERTAKER

...

ADDRESS

...

CAUSE OF DEATH in plain terms, so that it may be placed on back of certificate. See instructions on back of certificate.

D 68867

Registered No. C

City of BALTIMORE: (No. 319 Ward St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore; No. 57 / 7-10-10 St.; yrs. mos. ds.)

CORONER'S CERTIFICATE OF DEATH.

3-SEX *Female* t-COLOR OR RACE. *C* a-Single, *Wid*
Married,
Widowed,
or Divorced.
(Write the word.)

16-DATE OF DEATH, Dec 31 1932
(Month) (Day) (Year)

6-DATE OF BIRTH.....1.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

7-AGE 30 yrs. mos. ds. If LESS than 1 day, . . . hrs. or . . . min. *

The CAUSE OF DEATH* was as follows:

8. OCCUPATION:

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

Throat culture with - rays (supposed to
destroy bacteria) has been in use
of B. tuberculosis.

9-BIRTHPLACE
(State or Country)

(Duration) . . . yrs. . . mos. . . da

CONTRIBUTORY
(Secondary)

..... (Duration) yrs. mos. ds.

(Signed) John H. [illegible] M. D.
(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
20-NAME OF CEMETERY.	
21-NAME OF FUNERAL HOME.	
22-NAME OF MINISTER.	
23-NAME OF MINISTER.	
24-NAME OF MINISTER.	
25-NAME OF MINISTER.	
26-NAME OF MINISTER.	
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96-NAME OF MINISTER.	
97-NAME OF MINISTER.	
98-NAME OF MINISTER.	
99-NAME OF MINISTER.	
100-NAME OF MINISTER.	

20-UNDERTAKER.	ADDRESS
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State CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificate.

15- NOV 2 - 1932 ROBERT R. KRAUTER

ROBERT R. KRAUTER

Burlal Permis: 51234

20-UNDERTAKER.	ADDRESS
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Mrs. Chas. B. Jones, 1725 Ashland

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68868

CERTIFICATE OF DEATH.

D 68868

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *411 Friendship* ST. *9* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lottie Dixon(a) RESIDENCE. NO. *411 Friendship* ST. *9* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *40* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Joseph Dixon*6 DATE OF BIRTH (month, day, and year) *Sept 18 78*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

44

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer)

House maid

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

W. Va.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

W. Va.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

W. Va.

14

Informant (Address)

Viola Baim
411 Friendship

15

NOV 2 - 1922

ROBERT H. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 1* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

Oct 30, 19*22*, to *Oct 31*, 19*22*.that I last saw him alive on *Oct 31*, 19*22*.and that death occurred, on the date stated above, at *3 a.* m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia(duration) yrs. mos. ds. *2*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *W. Clyde Burns*, M. D.(Address) *2215 Pratt*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Ashbury Cemetery**November 4, 1922*

20 UNDERTAKER

ADDRESS

*Mrs Robert A Elliott**1725 Ashland*

CAUSE OF DEATH in plain terms, so that it may be properly translated. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68869

CERTIFICATE OF DEATH.

143-003

D 68869

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Bingham ST. 21 WARD)

2-FULL NAME

Margaret A. Luckart

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

806 Bingham

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Feb 22-1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Walter Curran

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Goetz

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

John Luckart 806 Bingham St

15

NOV 2-1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1-1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 19, 1922, to Nov 1, 1922,that I last saw him alive on Nov 1, 1922,and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia (Chronic)

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Stephen J. Graham, M. D.

, 19

(Address)

1277 Calverton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Redeemer Ch. Nov 4 1922

20 UNDERTAKER

ADDRESS

John Greblianchar425 S. Lea St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D-68870

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2054 Linden Ave. ST. 13 WARD)

2-FULL NAME Elise K. Lang

(a) RESIDENCE No. 2054 Linden Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 5 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Godfrey Lang

6 DATE OF BIRTH (month, day, and year) May 5, 1856

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

66

5

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Gerhard H. Kuhst

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14

Informant S. E. Lang (Address)

15

NOV 2-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1922

17 I HEREBY CERTIFY That I attended deceased from Oct 21, 1922 to Nov 1, 1922;

that I last saw him alive on Oct 31, 1922

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. ds.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) S. M. Langston, M. D.

1922 (Address) 826 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Woodlawn Ave

UNDERTAKER

W. J. Langston

DATE OF BURIAL

Nov 3 1922

ADDRESS

No. 10

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68871

CERTIFICATE OF DEATH.

REGISTERED D 68871

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred

yrs.

mos.

ds.

ST. Baltimore WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced—

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, ... hrs
or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

NOV 2 - 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-1-1922

17

I HEREBY CERTIFY, That I attended deceased from
10-30-1922 to 11-1-1922
that I last saw him alive on 11-1-1922and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritisCONTRIBUTORY (Secondary) Myocardial infarction
(duration) yrs. 1 mos. ds.
(duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? No Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy(Signed) W. H. H. H. H. M. D.11/2-1922 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

St. AuburnSam. W. Chase - son11/2/221400. Asher

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68872

CERTIFICATE OF DEATH.

D 68872

1-PLACE OF DEATH

CITY OF BALTIMORE: (No

215 S. Dallas

ST.

WARD) 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Geo W. Moore

(a) RESIDENCE. No.

215 S. Dallas

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos.

ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Annie Moore

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

General

(c) Name of employer

Indefinite

9 BIRTHPLACE (city or town) (State or country)

U. S.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

U. S.

(State or country)

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

U. S.

(State or country)

14

Informant

(Address)

Annie Moore
215 S. Dallas St

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

21/10 1922

17

I HEREBY CERTIFY, That I attended deceased from

12/10/1922, to 21/10/1922

that I last saw him alive on 20/10/1922

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, nephritis etc.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

Several

Heart failure

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

Elliott P. Boyd, M. D.

31/10/1922 Address

215 S. Dallas St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Laurel
John W. Henderson

Nov 5 1922

1301

D 68873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68873

CERTIFICATE OF DEATH. 185X

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Mayland General Hospital* ST., *185X* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. *Sallie Day*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos. *4*

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Day.

6 DATE OF BIRTH (month, day, and year)

Oct. 29, 1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

ind

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

J. Day
Sykesville Md

15

Filed

19

Registrar

Burial Permit No. *1122*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Oct. 29, 1922, to Nov. 2, 1922.*that I last saw him alive on *Nov. 2, 1922.*and that death occurred, on the date stated above, at *2 P. M.*

The CAUSE OF DEATH* was as follows:

*Fracture of Femur (open)
Chronic Nephritis*

(duration)

yrs.

mos. *5*

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos. *5*

ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

clinically

(Signed)

J. H. Williams M. D.

19

(Address)

185X Mayland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Jas. R. Meek
Sykesville Md

D 68875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68875

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 E. 22nd

ST. 9

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles J. Whittle

(a) RESIDENCE. No.

515 E. 22nd

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

67 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Married Whittle

6 DATE OF BIRTH (month, day, and year)

July 17, 1855

7 AGE

Years

Months

Days

67

3

19

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Independent

(b) General nature of industry, business, or establishment in which employed (or employer)

Fertilizing Co. 886

(c) Name of employer

J. H. + Sons

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Charles Whittle

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catherine Gabriel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mr. Whittle 515 E. 22nd St.

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov - 1 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 31, 1922, to Nov 1, 1922

that I last saw him alive on Nov 1, 1922

and that death occurred, on the date stated above, at 2:45 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration)

yrs.

mos.

8 mos.

CONTRIBUTORY (Secondary)

(duration)

2 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

(Signed)

C. J. Whittle

M. D.

11/1, 1922 (Address)

1279 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cem.

Nov. 3 1922

20 UNDERTAKER

ADDRESS

Margaret J. Flynn

1422 1/2 St.

CAUTION: SHOULD BE KEPT IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. SEE INSTRUCTIONS ON BACK OF CERTIFICATES.

OV 1-1922

D 68876

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68876

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2814 E Baltimore ST., 6 WARD)2-FULL NAME Anne Margant Schisler(a) RESIDENCE NO. 2814 E Baltimore ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Schisler6 DATE OF BIRTH (month, day, and year) May 4, 18847 AGE Years 88 Months 5 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)10 NAME OF FATHER Schmidt11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Dont Rudt13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Mr. Chas Schaffer (Address) 2814 E Baltimore St15 Filed Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 31 192217 HEREBY CERTIFY, That I attended deceased from 6/31/22, 1922 to 10/31/22, 1922 that I last saw him alive on 10/31/22, 1922and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Myo Carditis Chronic

CONTRIBUTORY (Secondary)

Pulmonary (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. J. Hermann, M. D.(Address) 7919 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL St. Johns Ev. Cem BaltimoreDATE OF BURIAL Nov 1 192220 UNDERTAKER John UerichADDRESS 2008 E Baltimore

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

2-1922

Partial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68877

D 68877

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Union Memorial Hospital
ST., 14 WARD

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

CITY OF BALTIMORE: (NO.)

2-FULL NAME

Mr John D Worthington

(a) RESIDENCE NO.

Belair, Md -

ST.,

WARD

Bel Air Mel.

(Usual place of abode)

Length of residence in city or town where death occurred

all 4 Days

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-2-1922

17 I HEREBY CERTIFY, That I attended deceased from
10-30-1922, to 11-2-1922.

that I last saw him alive on

11-2-1922

and that death occurred, on the date stated above, at

6 p. m.

The CAUSE OF DEATH* was as follows:

Strangulated hernia

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced, (write the word)

Married

5a If married, widowed or divorced
HUSBAND of
(or) WIFE of

Theresa M. Connick

6 DATE OF BIRTH (month, day, and year)

1855

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

67

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Retired

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Maryland

10 NAME OF FATHER

Mr Worthington

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md -

12 MAIDEN NAME OF MOTHER

Mary Dallam

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Md -

14 Informant
(Address)Mrs J. D. Worthington
Belair Md -

15

Filed

19

Registrar

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

yes

Date of 10-30-22

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

H. D. Connel

M. D.

19

(Address)

Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John O. Mitchell 1201 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified.
See instructions on back of certificates.
Tion is very important.

OV 2-1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68878

CERTIFICATE OF DEATH

D 68878

1-PLACE OF DEATH

Mayland General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST., 11 WARD)

2-FULL NAME

George W. Abernathy

(a) RESIDENCE NO.

Fullerton MS

ST., WARD

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

8 yrs.

mos.

1

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white

5 Single, Married, Widowed,

Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Kate Abernathy

6 DATE OF BIRTH (month, day, and year)

Aug 15, 1873

7 AGE

49

Years

2

Months

16

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Cath Gravel Co.

9 BIRTHPLACE (city or town) (State or country)

W. Va.

10 NAME OF FATHER

Alexander Abernathy

11 BIRTHPLACE OF FATHER (city or town)

W. Va.

(State or country)

12 MAIDEN NAME OF MOTHER

Jane Thomas

13 BIRTHPLACE OF MOTHER (city or town)

W. Va.

(State or country)

14

Informant (Address)

William G. Abernathy, 214 N. E. St.

15

NOV 3 - 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Oct 31, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 30th, 1922, to Oct 31, 1922that I last saw him alive on Oct 31st, 1922

and that death occurred, on the date stated above, at 1:50 P.m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia (sigmoid)

CONTRIBUTORY (Secondary) (duration) yrs. mos. 5 ds.

Intestinal paresis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Oct 31st 1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) James H. Wilkerson, M.D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park Cem

DATE OF BURIAL

Nov. 3, 1922.

20 UNDERTAKER

Mr. Mrs. John W. Tempel & Son 801 N. Fayette St.

D 68879

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68879

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

St. Joseph's Hosp.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST. 44 WARD)

2. FULL NAME

Robert Jones

(a) RESIDENCE No.

1010 Peach Al.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Maggie Thomas 28 12th Street, St

15

NOV 3 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1922, to Nov. 2, 1922.

that I last saw him alive on Nov. 2, 1922.

and that death occurred, on the date stated above, at 10:45 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of pylorus & stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Krager M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVA! Mt. Auburn Cemetery Nov 5 1922

20 UNDERTAKER

ADDRESS

M. Doyle 15 E. Lee St

D 68880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68880

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *808 h Gilmor* ST., *16* WARD)2-FULL NAME *Mary Elizabeth Cain*(a) RESIDENCE NO. *808 h Gilmor* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *73* yrs *9* mos *6* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widow*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*John T. Cain*6 DATE OF BIRTH (month, day, and year) *Jan 25 / 1849*7 AGE Years *73* Months *9* Days *6* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country)

10 NAME OF FATHER *Charles Karhoff*11 BIRTHPLACE OF FATHER (city or town, State or country) *Germany*12 MAIDEN NAME OF MOTHER *Minnie Wacker*13 BIRTHPLACE OF MOTHER (city or town, State or country) *Germany*

14

Informant (Address)

*Mr. James T. Cain
1949 Edmondson Ave*

15

Filed

NOV 3 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 2 1922*17 I HEREBY CERTIFY, That I attended deceased from *July 1*, 19*22*, to *Nov 2*, 19*22*.that I last saw her alive on *Nov 2*, 19*22*.and that death occurred, on the date stated above, at *8 a m.*

The CAUSE OF DEATH* was as follows:

Fatty degeneration of heart(duration) yrs. *5* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *William H. Denny* M. D.19 (Address) *1312 Light St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

John F. Denny

DATE OF BURIAL

ADDRESS

*Nov 6 1922
715 Light St*

Reason should be carefully stated in plain terms, so that it may be properly classified. Exact statement of OCCASION CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68881

CERTIFICATE OF DEATH.

D 68881

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 Orlean ST.; 6 WARD)2-FULL NAME Morris Carp(a) RESIDENCE. NO. 1606 Orleans St. ST. 6 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds.How long in U. S., if of foreign birth? 42 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Carp6 DATE OF BIRTH (month, day, and year) 18507 AGE Years 72 Months Days If LESS than 1 day. hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia10 NAME OF FATHER Samuel Carp11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia12 MAIDEN NAME OF MOTHER Wink13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant Jack Lewis (Address) 1439 E. Baltimore St.

NOV 3-1922

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1, 192217 I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1922 to Nov. 1, 1922, that I last saw him alive on Nov. 1, 1922, and that death occurred, on the date stated above, at 11:15 P. m. The CAUSE OF DEATH* was as follows:Atherosclerosis
Angina - PectorisCONTRIBUTORY (Secondary) Coronary Embolus + Acute Cardiac Dehydration

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. J. H. Hargraves M. D.
(Address) 2002 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Hehrum Friends of the City 11/3 1922

20 UNDERTAKER ADDRESS

Jack Lewis 1439 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter statement of cause of death on back of certificate. See instructions on back of certificates.

D 68882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., If of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from Oct 20, 1922, to Nov. 1, 1922,

that I last saw him alive on Oct 31, 1922,

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address) 1211 Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificates.

NOV 3-1922

Holy Redeemer Nov. 4, 1922
Wm. Cook, 507 E. North Ave.

N. B.—Every item of information should be stated in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68883

CERTIFICATE OF DEATH.

D 68883

1-PLACE OF DEATH

City of BALTIMORE: (No. *Emergency Hospital* St. *4* Ward)

Registered No. C.....

2-FULL NAME *Mr. Robert A. Gallouay*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *726 W. Lexington St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Single* (Write the word.)

6-DATE OF BIRTH, 1. (Month) (Day) (Year)

7-AGE, *39* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Carpenter* (b) General nature of industry, business, or establishment in which employed (or employer) *015*

9-BIRTHPLACE, (State or Country), *Michigan*

10-NAME OF FATHER, *Mr. Gallouay*

11-BIRTHPLACE OF FATHER, (State or Country), *Canada*

12-MAIDEN NAME OF MOTHER, *Anna G. McKee*

13-BIRTHPLACE OF MOTHER, (State or Country), *Mich*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *J. Dr. Gallouay*

(Address) *726 W. Lexington St.*

15- *NOV 3 - 1922* ROBERT R. KRAUTER, Registrar.

Burial Permit *Given*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 22*, 192*2*. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Fractured Skull*

CONTRIBUTORY (Secondary) *Struck by auto truck*

(Signed) *H. H. Jones* M. D. (Coroner.) *113*, 192*2* (Address) *117 W. Lexington St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Clifford McKee *11/4/22*

20-UNDERTAKER, ADDRESS

C. Jones *111 S. Belmont St.*

D 68884

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 68884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp.* St. *13* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....

(Residence in Baltimore: No. *2437 E. Ewing St.* St.; yrs. *4* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

*Caucasian*5-Married,
Widowed,
or Divorced,
(Write the word.)
Married

6-DATE OF BIRTH.

June 21 1922
(Month) (Day) (Year)

7-AGE,

yrs. *9* mos. *11* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Child*

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,

(State or Country). *Baltimore*10-NAME OF FATHER, *Edmund Griffin*

11-BIRTHPLACE OF FATHER,

(State or Country). *Md*12-MAIDEN NAME OF MOTHER, *Lucy Brooks*

13-BIRTHPLACE OF MOTHER,

(State or Country). *Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Edmund Griffin (Father)*(Address) *2437 E. Ewing St.*

15-

Filed

NOV 3 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov
(Month)*1*
(Day)*1922*
(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)thereon and from the evidence obtained by said *inquiry*
(Inquest, au-topsy or inquiry.) find that said deceased came to *death*
on the day stated above.

The CAUSE OF DEATH* was as follows:

*Thrombosis (Intestinally Epinephrine)**(Partially Autopsy at Hospital)*
(No return) (Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Water*

M. D.

(Coroner)

11-2 1922 (Address) *508 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*McCurran**Nov 3rd* 1922

20-UNDERTAKER,

ADDRESS

Samuel Wright *664 E. Carey*

N. B.—Every item of information should be carefully supplied. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificate.

D 68885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68885

1-PLACE OF DEATH

City of BALTIMORE: (No. 1508 Hanover St. St. 23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Gertrude A. Einwachter.

48 10 3
St.; yrs., mos., ds.)

(Residence in Baltimore: No. 1508 Hanover St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female. 4-COLOR OR RACE, White. 5-Single, Married, Widowed, or Divorced, Married.
(Write the word.)6-DATE OF BIRTH, December 29th. 1873, 1.
(Month) (Day) (Year)

7-AGE, 48 yrs. 10 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, None.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),

Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John W. Friedhofer.

11-BIRTHPLACE OF FATHER, Baltimore, Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Sarah Whiteford.

13-BIRTHPLACE OF MOTHER, Balto. Co. Md.
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Einwachter. (husband)

(Address) 1508 Hanover St.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 1st. 1922, 192.
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or Inquiry.)thereon and from the evidence obtained by said inquiry and that said deceased came to her death
(Inquest, autopsy or Inquiry.)
on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating gas poisoning.
Suicide.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)(Signed) Otto M. Einwachter, M.D.
(Coroner)

Nov. 3rd 1922. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Baltimore, Md. Nov 3rd 1922

20-UNDERTAKER,

ADDRESS 1034

N. B.—Every item of information should be carefully checked, so that it may be properly classified. Exact statement of state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

NOV 3 - 1922 ROBERT R. KRAUTER,
Burial Permit Clerk

KREIS
HEALTH DEPARTMENT—CITY OF BALTIMORE D 68886

D 68886

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, (yrs. mos. ds.) If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER, William Dwyer

11-BIRTHPLACE OF FATHER, (State or Country), Mass.

12-MAIDEN NAME OF MOTHER, Ann Gillespie

13-BIRTHPLACE OF MOTHER, (State or Country), Mass.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Nannie Kreis

(Address) 12 Burke Ave., Towson

15- NOV 3 - 1922

ROBERT R. KRAUTER,

Burial Permit Officer

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures of Ribs
Auto accident
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fracture of Skull

(Signed) Dr. William H. B. M. D. (Coroner.)
(Address) 192 ...

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Cathedral Cemetery 11/ 19 22

20-UNDERTAKER, ADDRESS

Henry W. Moore & Son 805 N. Calvert

N. B.—Every item of information should be carefully supplied in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

D 68887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 68887

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *4* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Harry Earnest Zepp-*(a) RESIDENCE. NO. *Granite Road-*

(Usual place of abode)

ST.

WARD.

Length of residence in city or town where death occurred *7* yrs. *6* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

*male**White**Single*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept. 1894*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*28**1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Printing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Granite-

10 NAME OF FATHER

George A. Zepp-

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Carroll County-

12 MAIDEN NAME OF MOTHER

Emma R. Albright

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Woodstock

14

Informant (Address)

Sister - Kate Zepp - Granite Bldg. Co. Ind.

15

Date

NOV 3-1922

ROBERT R. KRAUTER,

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct-31-1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct-18-* 19 *22*, to *Oct-31-* 19 *22*, that I last saw him alive on *Oct-31st* 19 *22*, and that death occurred, on the date stated above, at *11-17 P. m.*

The CAUSE OF DEATH* was as follows:

Brain Abscess.
Left frontal convolution(duration) yrs. mos. ds. *28*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Partial*

What test confirmed diagnosis?

(Signed) *J. H. Zepp*, M. D.19 1922 Address *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Granite Bldg. Co. Ind Nov-3-1922

20 UNDERTAKER

ADDRESS

*Harry H. Witzke**1531 W. Lombard*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 68888

129 ✓ D 68888

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina Metzger

(a) RESIDENCE NO. 203 S. Bouldin ST., WARD
(Usual place of abode) (If none)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed,
or Divorced, (write the word) *Married*

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of August H. Metzger

6 DATE OF BIRTH (month, day, and year) Oct. 4-1874

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	48	-	28	

16 DATE OF DEATH (month, day, and year) Nov / 19 22

I HEREBY CERTIFY, That I attended deceased from
Oct 1, 1922, to Nov 1, 1922,

that I last saw her alive on Oct 31, 1922

and that death occurred, on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ... Baltimore
(State or country) Md

10 NAME OF FATHER *John Weinecke*

11 BIRTHPLACE OF FATHER (city or town)
(State or country) *German*

12 MAIDEN NAME OF MOTHER *Caroline Hart*

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant August H. Metzger
(Address) 203 S. Bouldin St.

15 NOV 3 - 1922 ROBERT R. KRAUTER.
Filed

..... (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

... (duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? *Cherry-blossom*

(Signed) Thrace B. Nelson, M. D.

19 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL
Oaklawn Cemetery

70 UNDERTAKER
Girkler + Girkler

DATE OF BURIAL

Nov. 4 1922

ADDRESS
1739 E. Cagney

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *268889* *Little Sisters of the Poor* ST. *10* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *John Ford*(a) RESIDENCE. NO. *Preston Valley* ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *44* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widower*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE *69-69* Yrs. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Ireland* (State or country)10 NAME OF FATHER *James Ford*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Mary Cohen*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Little Sisters of the Poor* (Address) *Preston Valley*15 Filed *NOV 3 - 1922* 19 *ROBERT R. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *October 31* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *to record* 19*22*, to *Oct 29*, 19*22*, that I last saw him alive on *Oct 29*, 19*22*, and that death occurred, on the date stated above, at *9 P. M.*

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Conc*

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. A. Warner*, M. D.1, 19*22* Address *1135 Valley St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cem *Nov 4* 19*22*

20 UNDERTAKER

ADDRESS *St.**John J. Corran* *901 Hollins*

Information should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS AND PRESENT CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

68890

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Christ's Institution Hospital

CITY OF BALTIMORE: (No. 704 Essex St. ST., 10 WARD)

2-FULL NAME

Ellen B. Harrison
131 New St Petersburg Va.

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 1 mos.

ds. How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Colored Single

5a If married, widowed, or divorced HUSBAND of or WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

NOV 3 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 - 1922

17 I HEREBY CERTIFY That I attended deceased from October 1 - 1922 to November 2, 1922 that I last saw her alive on November 2, 1922 and that death occurred, on the date stated above, at 12:55 A.M.

The CAUSE OF DEATH* was as follows:

apoplexy
Carcinoma of uterus (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of uterus (duration) 1 yrs. 2 mos. 10 ds.

18 Where was disease contracted if not at place of death? Petersburg, Va.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. W. H. Kennard M. D. 78 INDCR at 11-7-1922 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-NOVA

Petersburg Va. 11/5/1922

20 UNDERTAKER Mrs. R. H. Elliot

ADDRESS Ashland Ave Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1519 Retreat ST., 13 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

33 yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,

or Divorced. (write the word)

Female White Widowed5a If married, widowed or divorced
HUSBAND of
(or) WIFE ofWalter Fitzmaurice

6 DATE OF BIRTH (month, day, and year)

Aug 24 1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.652

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workNone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Ireland

10 NAME OF FATHER

Frank Kelly

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Don't know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant
(Address)Frank Fitzmaurice
1821 Appleton St

15

Filed

NOV 3-1922

ROBERT B. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 1st 1922

17

HEREBY CERTIFY,

that I attended deceased from

Jan. 1922 to

Nov 1, 1922

that I last saw him alive on

Oct 31/22and that death occurred, on the date stated above, at 10-40 m.

The CAUSE OF DEATH* was as follows:

6 aeuricmia. Blood
1 morning ulcerus ArterCONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVALSt Peters

DATE OF BURIAL

Nov 4 1922

20 UNDERTAKER

Robt Turner Inc
1442 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.: 8 WARD)

2-FULL NAME

(a) RESIDENCE. NO.

ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

19

NOV 3-1922

Bureau Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1922, to Nov 2, 1922,

that I last saw him alive on Nov 2, 1922,

and that death occurred, on the date stated above, at 8:30 A. M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. B. Friedman, M. D.

11-2-1922 (Address) 682 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London St. Cemetery no 3 1922

20 UNDERTAKER

ADDRESS

James Dignan 1000 S

Exact statement of OCCUPATION should be furnished in plain terms, so that it may be properly classified. See instructions on back of certificates.

JOSEPH M. KRAUTER,

268893 HEALTH DEPARTMENT—CITY OF BALTIMORE 268893

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Cole Ave. Rassburg ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lena Schultz
(a) RESIDENCE. No. 114 Cole Ave. Rassburg

WARD.

(If nonresident give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest F. Schultz

6 DATE OF BIRTH (month, day, and year) Dec 3 1883

7 AGE 38 Years 10 Months 29 Days / If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Julius Lueck

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Wilhelmina Winkowski

13 BIRTHPLACE OF MOTHER (city) (State or country)

Germany

Informant (Address)

Ernest F. Schultz
114 Cole Ave.

Filed NOV 3 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 12 1922 to Nov 1 1922 that I last saw her alive on Nov 1 1922 and that death occurred, on the date stated above, at 9:45 a.m. The CAUSE OF DEATH was as follows: Diabetes

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

3 yrs Heart Failure

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park

DATE OF BURIAL

Nov 4 1922

20 UNDERTAKER

C. W. Dill

ADDRESS 3109 Fredk. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

NOV 3 - 1922

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-30 1922

17

I HEREBY CERTIFY, That I attended deceased from

8-25 1922 to 10-30 1922

that I last saw him alive on 10-30 1922

and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of right tonsil with metastases to neck

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of operation

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. Richardson Joyner M. D.

19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health,

Per. Wm. E. WOODALL

DATE OF BURIAL

19

ADDRESS

NOV 3 - 1922

Information should be carefully supplied so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD) 129

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Albert Wilson

(a) RESIDENCE NO. Unknown ST. _____ WARD _____

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE Years Months Days If LESS than 1 day, hrs or min. 63 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records (Address) JOHN HOPKINS HOSPITAL

15 Filed NOV 3 - 1922 ROBERT R. KRAUER Registrar

DEPUTY CLERK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 29 1922

17 I HEREBY CERTIFY, That I attended deceased from October 21, 1922 to October 29, 1922, that I last saw him alive on October 29, 1922, and that death occurred, on the date stated above, at 6:40 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

CONTRIBUTORY (Secondary) Hypertension (duration) 1 yrs. mos. ds. (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles A. Neill M. D.

10/30/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

JOHN HOPKINS HOSPITAL

20 UNDERTAKER Wm. E. Woodball

Wm. E. Woodball

DATE OF BURIAL

ADDRESS

NOV 3 - 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 75 WARD)

2-FULL NAME Horace Price

(1) RESIDENCE NO.Unknown
(Usual place of abode)

ST., WARD

WARD
(If non-resident give city or town and State)

(a) RESIDENCE				(b) How long in U. S., if of foreign birth?		
(Usual place of abode)				ys.	mos.	ds.
Length of residence in city or town where death occurred				ys.	mos.	ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1870

6 DATE OF BIRTH (month, day, and year)				
7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs or.....min.
52		--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) North Carolina
(State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER	Unknown
--------------------------	---------

13 BIRTHPLACE OF MOTHER (city or town).....Unknown
(State or country)

14	Informant	Hospital Records
	(Address)	Municipal Hospital

15 Filed 19 Rep

15 Filed 19 Res

1963-1964

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct. 31 1922

17 I HEREBY CERTIFY, That I attended deceased from
October 5, 1922, to October 31, 1922.

that I last saw him alive on October 31, 1922.

and that death occurred, on the date stated above, at 7:45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTOR (Secondary) *Arthur J. ...* (duration) 16 yrs. mos. ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis: _____
(Signed) Arthur H. Hines, M. D.

10/31/22 Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL 1922

MOVAL
NS HOPKINS HOSPITAL

20 UNDERTAKER.

Commissioner Health.

Mr. Wm. B. Wood

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed

RUDOLPH R. KRAUTER, Registrar

NOV 3 - 1922

Burial Permt Clerk.

WARD

WARD.

(If nonresident give city or town and State)

How long in U. S. if of foreign birth?

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: *St. Luke's Hospital*

WARD

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)
Length of residence in city or town where death occurred

ST.

WARD.

(If nonresident, give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

NOV 3 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 3 1922*17 I HEREBY CERTIFY, That I attended deceased from
Oct. 24, 19*22*, to *Nov 3*, 19*22*,
that I last saw *her* alive on *Nov. 2*, 19*22*,
and that death occurred, on the date stated above, at *3:00 A* m.

The CAUSE OF DEATH* was as follows:

*Measles*CONTRIBUTORY
(Secondary)

(duration)

yrs. — mos. *12* ds.

(duration)

yrs. — mos. *11* ds.18 Where was disease contracted
if not at place of death?*at home*Did an operation precede death? *no* Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed)

B. K. Krawmer M. D.*11/3/22* (Address)*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Hehren Wash Road**11-3 1922*

20 UNDERTAKER

Jack Lewis 1439 E. Balt St

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Neer Hospital* ST. *12* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

NOV 3 - 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 1, 1922, to Nov. 2, 1922.

that I last saw her alive on Nov. 2, 1922,

and that death occurred, on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY
(Secondary)

(duration)

mos

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

11/3, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

068900 HEALTH DEPARTMENT—CITY OF BALTIMORE 068900 CERTIFICATE OF DEATH. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E Balto ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No. 2100 E Balto ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female White Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

NOV 3 - 1922

ROBERT R. KRAUTER,

Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Nov 3, 1922,

that I last saw him alive on Nov 3, 1922,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Gastric Cancer

CONTRIBUTORY (Secondary) (duration) 1 yrs. mos. ds. Myocarditis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Bayne, M. D.

11/3, 1922 (Address) 2100 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Home for Incurable 11/3 1922

20 UNDERTAKER

ADDRESS 11/27

E. Balto

D68901

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Joseph's Hosp*)ST. *135* WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

white

Widowed.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Late Mrs Elizabeth Busch

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day,hrs.
ormin.

58

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Meator

(b) General nature of industry, business, or establishment in which employed (or employer)

Maker

(c) Name of employer

Maryland

9 BIRTHPLACE (city or town)
(State or country)Meator Works
Balt.

10 NAME OF FATHER

John Busch.

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

E. Nickel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Balt.

14

Informant

(Address)

Mrs. John Busch.
4922 Hayford Ave

15

Filed

19

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct 17 19 22 to Nov 2 19 22

that I last saw him alive on Nov 1 19 22

and that death occurred, on the date stated above, at 2 30 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

CONTRIBUTORY (duration) yrs. mos. ds.
(Secondary) Cellulitis Neck
Cause unknown mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? yes Date of 10/26/22

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J W Koury, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

Nov. 4 1922

20 UNDERTAKER

ADDRESS

George - J. Ruth 1235 Hayford Ave.

1268902 HEALTH DEPARTMENT—CITY OF BALTIMORE 1268902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 530 N. Chester ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Laurie Snyder

(a) RESIDENCE NO.

530 N. Chester ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female. White Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Jacob Snyder

6 DATE OF BIRTH (month, day, and year) March 7, 1855

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

67 7 25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Henry Meiss

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

Florence Snyder

15

Filed

19

Special Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 30, 1922, to Nov. 1, 1922;

that I last saw him alive on Nov. 1, 1922;

and that death occurred, on the date stated above, at 11:50 a.m.

The CAUSE OF DEATH* was as follows:

Uræmic Coma.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Chronic Intestinal Dependent

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? None.

(Signed)

Thos. J. Stevens, M. D.

11/2, 1922 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Parkwood Cemetery

Nov 4 1922

20 UNDERTAKER

Lilly Ziel

ADDRESS

4038 W. 1st St.

10.68903 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68903
185

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 Maple Ave. WARD 5)

2. FULL NAME

(a) RESIDENCE NO. 117 Maple Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

ST. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (give the word)

female

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14, 1838

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15

Filed

3-1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 18, 1922, to Nov 2, 1922, that I last saw her alive on Nov 2, 1922,

and that death occurred, on the date stated above, at 4.45 P.M.

The CAUSE OF DEATH* was as follows:

Hypertensive Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Fracture of Femur

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard W. Jones M.D.

162 1922 (Address) 222 Augusta St.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL DATE OF BURIAL

London Park Nov 4 1922

20 UNDERTAKER ADDRESS

Robert Brookman Hollins

10.68904 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68904

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1100 Block Pennsylvania st 14 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna L. Baylon

(Residence in Baltimore: No. 2200 McCulloch st St. 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female 4-COLOR OR RACE, Col 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Domestic (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va

10-NAME OF FATHER, A. Williams

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, Ada Henry

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ada Hudson

(Address) 2200 McCulloch st

15- Robert P. Harrison, Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. H. Harrison, M. D. (Coroner.)

11-31, 1922 (Address) 1131 South St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Laurel County Nov 6, 1922

20-UNDERTAKER, ADDRESS

George T. A. Allen 513 Laurel St

state CAUSE OF DEATH in plain terms, so that it may be properly entered is very important. See instructions on back of certificate.

20.68905 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1933 White ST. 70 WARD)

2-FULL NAME

Wana Lee

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

1933 White

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male Colored Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Adelia Lee

6 DATE OF BIRTH (month, day, and year)

Sept 9, 1887

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

35

1

22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

Hotel 086

(c) Name of employer

Art Large

9 BIRTHPLACE (city or town) (State or country)

Annapolis Md

10 NAME OF FATHER

Benjamin Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Annapolis Md

12 MAIDEN NAME OF MOTHER

Anna Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

Informant (Address)

Theodocia Cole 1933 White St.

3-1922

Robert P. Harrison,

19

Registrar

Burial Permit 2122

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 28, 1922, to Nov 2, 1922,

that I last saw him alive on Nov 7, 1922,

and that death occurred, on the date stated above, at 104 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY Chronic Bronchitis (Secondary)

(duration) 7 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

11 (Signed) Bernard P. French M. D.

2, 1922 (Address) 1707 Edmundson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

DATE OF BURIAL

Mt Auburn City 11-6 1922

20 UNDERTAKER

ADDRESS

George H. Holland 1631 Duval

ation should be carefully supplied. Exact statement of OCCUR- CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Coliapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "~~PUERPERAL septicemia~~," "~~PUERPERAL peritonitis~~," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Probably Tubercular

10.68906 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68906

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 Clarkson ST., 23 WARD)

2-FULL NAME

Alphonse Truffer.

(a) RESIDENCE NO.

1636 Clarkson

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Susanna Truffer.

6 DATE OF BIRTH (month, day, and year)

June 10, 1850

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

72

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cooper.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Mr. Frank.

9 BIRTHPLACE (city or town) (State or country)

Switzerland.

10 NAME OF FATHER

August Truffer.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Switzerland.

12 MAIDEN NAME OF MOTHER

Mary Truffer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Switzerland.

14

Informant (Address)

Susanna Truffer, 1636 Clarkson St.

15

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 22, 1922, to Nov 1, 1922,

that I last saw him alive on Oct 31, 1922,

and that death occurred, on the date stated above, at 6:35 A. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. H. Campbell, M. D.

1, 1922 (Address) 1644 Hancock St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Cross, G. A. Co.

DATE OF BURIAL

11-4 1922

20 UNDERTAKER

E. B. Harle

ADDRESS

115 E. West St.

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

3-1922

Burial Permit Clerk

dl. 68907 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68907
90

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. ...)

Clark Lane Arlington

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Emma F. Stubbs

(a) RESIDENCE NO.

Clark Lane, Arlington

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. - mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Joseph S. Stubbs

6 DATE OF BIRTH (month, day, and year) Oct 30, 1844

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs. or ... min.

78

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md

10 NAME OF FATHER

John Beard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md

12 MAIDEN NAME OF MOTHER

Elizabeth Norris Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Mary Virginia Smith (daughter)
Clark Lane, Arlington, Balto, Md

15

1922

Robert F. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1922

17

I HEREBY CERTIFY That I attended deceased from Oct 30, 1922, to Nov 2, 1922.

that I last saw her alive on Nov 2, 1922, at 2 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 4 ds. Mitral Regurgitation

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

O. A. Duvalle, M. D.

(Address)

1817 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Greenmount

DATE OF BURIAL

Nov 4 1922

20 UNDERTAKER

Wm Jackson & Sons

ADDRESS

north
+ Penna ave

Exact statement of OCCURRENCE should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

OV 3

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (NO.

JOHNS HOPKINS HOSPITAL

ST.

WARD

2. FULL NAME

Annie S. Shelley

(a) RESIDENCE NO.

320 E. Market St. York Pa.

WARD

York Pa.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. 13 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept. 19-1881

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

41

1

15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Pa.

10 NAME OF FATHER

Wm. S. Shelley

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Annie Beer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Pa.

14

Informant
(Address)

JOHNS HOPKINS HOSPITAL

15

Filed

Robert P. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 3- 1922

17

I HEREBY CERTIFY, That I attended deceased from

Aug 23, 1922, to

Nov 3, 1922.

that I last saw him alive on

Nov 3- 1922.

and that death occurred, on the date stated above, at

340 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary.

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds.

Pleural effusion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Yes. Date of

June, 22.

Was there an autopsy? Yes.

What test confirmed diagnosis? No special test

(Signed) J. H. Harrison, M. D.

11-3, 1922 Address: Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOV.

10/16 1922

20 UNDERTAKER

Wm. Cook

DATE OF BURIAL

11/4/22

ADDRESS

502 E. N.

nation should be carefully supplied. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

3-1922

Burial Permit Clerk.

DL 68909

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL 68909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 7 W. York St. St. 2274-001 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Annie Gray. (C)

(Residence in Baltimore: No. 7 W. York St. St.; yrs. 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female. 4-COLOR OR RACE. Colored. 5-Single, Married, Widowed, or Divorced. Widow. (Write the word.)

6-DATE OF BIRTH. Do not know. (Month) (Day) (Year)

7-AGE. 60 yrs. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Baltimore, Md.

10-NAME OF FATHER. John Stewart. (C)

11-BIRTHPLACE OF FATHER. (State or Country). Maryland.

12-MAIDEN NAME OF MOTHER. Do not know.

13-BIRTHPLACE OF MOTHER. (State or Country). Do not know.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Carter, (C) grand-daughter. (Address) 228 Rock St.

15- Robert P. Harrison, Registrar.

Filed 1922-10-10-1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. November 2nd. 1922. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to death on the day stated above. (Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Cerebral Globulex.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Otto M. Reinhard, M. D. (Coroner)

Nov. 3rd. 1922 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

20-UNDERTAKER. Address 1140 N. ...

state CAUSE OF DEATH in plain terms, so that it may be properly understood. See instructions on back of certificate.

10.68910

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68910

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Agnes Hospital

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Baby Liezowski

(a) RESIDENCE NO.

(Usual place of abode)

St. Agnes Hospital

ST.

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

20

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

October 14-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

20 days

20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Stanislaus Liezowski

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Mrs. L. Liezowski
1444 Paul St.

15

Robert F. Harrison,

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 2 1922

17

I HEREBY CERTIFY, That I attended deceased from 10-14-1922 to 11-2-1922

that I last saw him alive on

11-2-1922

and that death occurred, on the date stated above, at

11 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

St. Agnes Hospital

Did an operation precede death?

no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Rosary Cem.

DATE OF BURIAL

Nov 4 1922

20 UNDERTAKER

M. F. Sadowski

ADDRESS

705 S. Ann St.

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OV 4-1922

10.68911

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68911

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1116 Balto. St. 11 Ward)

2-FULL NAME

(Residence in Baltimore: No. 1116 Balto. St.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced (Write the word.)

6-DATE OF BIRTH

7-AGE

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

1922 (Year)

17-

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.)

and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

(Duration)

(Address)

(Coroner.)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

state CAUSE OF DEATH in plain terms, so that it may be properly stated on back of certificate. is very important. See instructions on back of certificate.

4-1922

Burial Permit class.

D. 68912 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68912

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1121 Mc Donough ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary. M. Dieter

(a) RESIDENCE NO.

1121 Mc Donough

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? 129 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced

HUSBAND of the late Charles J. Dieter (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Apr. 11 1846

7 AGE

Years 76

Months 6

Days 21

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Nicholas A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Anna Senhof

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Mrs. Catherine Price 1121 Mc Donough St.

15

Filed

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1922, to Nov. 2, 1922,

that I last saw him alive on Nov. 2, 1922,

and that death occurred, on the date stated above, at 6:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration), 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocardial degeneration

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A. Hartman, M. D.

2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery Nov. 6 1922

20 UNDERTAKER

ADDRESS

Henry Hockson 1301 E. Egan St.

Exact statement of OCCASION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

V 4 -1922

Burial Permit 2122

20.68913

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.68913

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3803 Hamilton ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary F. Jones

(a) RESIDENCE NO.

3803 Hamilton ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs. 0 mos.

ds. How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct-12-1843

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7922

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

House work

(c) Name of employer

P. H. Ditty

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Not known

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Not known

14

Informant (Address)

P. H. Ditty
3803 Hamilton

15

Filed

Robert F. Harrison,

19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 19 22

17

I HEREBY CERTIFY, That I attended deceased from Oct 28, 1922 to Nov 2, 1922.that I last saw her alive on Nov 2, 1922.and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration)

yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Lobar pneumonia

(duration)

yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? physical

(Signed)

Walter S. Hallett M. D.Nov 2, 1922 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mt Auburn CtNov 4 19 22

20 UNDERTAKER

ADDRESS

J. L. Brown and Son108 W. Montg

Information should be carefully supplied. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

10.68914 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68914

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 202 Joy ally St. 4 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 202 Joy ally St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Chinese

5-Single, Married, Widowed, or Divorced. (Write the word.)

Married

6-DATE OF BIRTH

Don't know

(Month) (Day) (Year)

7-AGE

68

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Cook

9-BIRTHPLACE, (State or Country).

China

10-NAME OF FATHER

Don't know

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Dr. Don

(Address)

114 Park Ave

15-

Robert P. Harrison,

Filed

1922

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Nov 3

1922

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum

(Duration) about 1 year

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed)

H. G. ... M. D.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Baltimore Cemetery

Nov. 4, 1922

20-UNDERTAKER

ADDRESS

John O. Mitchell

1201 W. Fayette St.

N. B.—Every item of information in plain terms, so that it may be properly classified. Enter state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

4-1922 Burial Permit 4125

D.68915 HEALTH DEPARTMENT—CITY OF BALTIMORE D.68915

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 Ash St. ST., 13 WARD)

2-FULL NAME

Mary M. Hilberg

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

3400 Ash St.

ST., 13 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX Female COLOR OR RACE White Single, Married, Widowed, Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John C. Hilberg

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1839

7 AGE Years 82 Months 11 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Co. Maryland

10 NAME OF FATHER

John C. Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Maryland

12 MAIDEN NAME OF MOTHER

Elija Norwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Miss Mary C. Hilberg 3400 Ash St.

15

Signed

Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2, 1922

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1922, to Nov. 2, 1922, that I last saw her alive on Nov 2, 1922, and that death occurred, on the date stated above, at 7:40 A. m.

The CAUSE OF DEATH* was as follows:

Anthraxis of liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

No

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Physical Examination

(Signed)

C. J. Davis, M. D.

2-3, 1922 (Address)

800 W 33 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

BIAL

Woodlawn

DATE OF BURIAL

Nov. 4, 1922

20 UNDERTAKER

ADDRESS

Horace H. Burgee 363 Kellard Rd.

Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

4-1922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Non-Alcoholic

10.68916

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.68916

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

8 dlewey av

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary A. E. Best

(a) RESIDENCE. No.

8 dlewey av

ST.:

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

10

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

col

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1847

7 AGE

75

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ft. Monmouth, Va

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va

12 MAIDEN NAME OF MOTHER

Catherine Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va

14

Informant (Address)

John Brown 8 dlewey av

15

Robert E. HADLICH, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 29, 1922, to Nov 1, 1922

that I last saw her alive on Nov 1, 1922

and that death occurred, on the date stated above, at 11-45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

8 dlewey

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) M. H. Pearson, M. D.

19 (Address) 2105 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn

11 5 1922

20 UNDERTAKER

J. H. Hensley

ADDRESS

21 Riddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact classification is very important. See instructions on back of certificates.

V 4-1922

20.68917 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68917

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 Junction Alley)

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)
Length of residence in city or town where death occurred

7 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced, (write the word)6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2 1922

17 I HEREBY CERTIFY, That I attended deceased from

Oct 31, 1922, to Nov 1, 1922.

that I last saw her alive on Nov 1, 1922.

and that death occurred, on the date stated above, at 4:45 p.m.

The CAUSE OF DEATH* was as follows:

Acute General peritonitis
from extension of
inflammation from
stomach (duration) 7 yrs. 7 mos. 30 ds.?CONTRIBUTORY Acute Catarrhal In-
flammation (duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) G. D. Hall M. D.

, 19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Mitchell Sta

DATE OF BURIAL

20 UNDERTAKER Calpepper & Co

ADDRESS 578

Samuel H. Hinkle

tion should be carefully supplied. XEROX should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

4-1922

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, 6 hrs.
or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)14 Informant
(Address)

15 Filed

19

Robert P. Harrison, Registrar

ST.:

WARD)

ST.,

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

Nov 1, 1922, to Nov 1, 1922

that I last saw him alive on Nov 1, 1922

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Pre-eclampsia
(34 wks)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

OV 4-1922

Burial Permit Clerk

1068919 HEALTH DEPARTMENT—CITY OF BALTIMORE 1068919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1024 W Barre St ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretta Wich

(a) RESIDENCE. No. 1024 W Barre St ST. 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

Female White Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Daniel Wich

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
76 2 20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

10 NAME OF FATHER Adam Belloff

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Cath. Nightengale

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14

Informant Daniel Wich
(Address) 1024 W Barre St

15

Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Dec 17, 1922, to Nov. 3, 1922.

that I last saw her alive on Nov. 2, 1922.

and that death occurred, on the date stated above, at 6:30 A. M.

The CAUSE OF DEATH* was as follows:

Enteritis Chronic

(duration) yrs. 10 mos. ds.

CONTRIBUTORY Exhaustion
(Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [Signature] M. D.

11,3,22 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Paul's Cemetery, Vol. 6, p. 6 1922

20 UNDERTAKER

Geo. Leimbach & Son

ADDRESS

647 N. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

NOV 4-1922

Burial Permit Blank.

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No other history

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)2-FULL NAME Richard Sofinowsky(a) RESIDENCE NO. Wise Ave.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 1 mos. 1 ds.

How long in U. S., if of foreign birth?

yrs. 1 mos. 1 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) May 15 - 1922

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland10 NAME OF FATHER Frank Sofinowsky11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland12 MAIDEN NAME OF MOTHER Kate Brodowsky13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland14 Informant JOHNS HOPKINS HOSPITAL

(Address)

15

Filed 1922

19

Burial Permit alack

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1st 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 2nd, 19 22, to Nov. 1st, 19 22.that I last saw him alive on Nov. 1st, 19 22.and that death occurred, on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)(duration) yrs. 4 mos. 4 ds.CONTRIBUTORY
(Secondary)(duration) yrs. 4 mos. 4 ds.18 Where was disease contracted
if not at place of death? At homeDid an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed)

H. H. Weol, M. D.

19 (Address)

Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Oak Lawn Cem. Nov. 4 19 22

20 UNDERTAKER

H. Sander Sons

ADDRESS

1710 Kent St.

Information should be carefully supplied. All information should be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates.

DL. 68921

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL. 68921

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1525 McElderry ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Emily Walker(a) RESIDENCE NO. 1525 McElderry ST., 7 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child6 DATE OF BIRTH (month, day, and year) Sept. 1921

7 AGE / Years / Months / Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)10 NAME OF FATHER Frank Walker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Georgia12 MAIDEN NAME OF MOTHER Annabelle Williams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Georgia14 Informant Frank Walker (Address) 1525 McElderry St.15 Filed Robert P. Harrison 19 922

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-3-1922

17

I HEREBY CERTIFY, That I attended deceased from 11-2-, 1922, to 11-3-, 1922, that I last saw her alive on 11-3-, 1922, and that death occurred, on the date stated above, at 4,40 A.m. The CAUSE OF DEATH* was as follows:Broncho-pneumonia(duration) yrs. mos. 14 ds.CONTRIBUTORY Pertussis (Secondary)(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. Gargill, M. D.11-3-1922 (Address) 611-N-Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel Cemetery

DATE OF BURIAL

November 5, 1922

20 UNDERTAKER

Mrs Robert A ElliottADDRESS 1225Ashland

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Burial Permit No.

D. 68922 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 68922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.:

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

30 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female

Colored

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Hife

6 DATE OF BIRTH (month, day, and

Unknown 1870

7 AGE

52

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind

10 NAME OF FATHER

Harris Shilin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind

12 MAIDEN NAME OF MOTHER

Caroline Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind

14

Informant (Address)

Sydney Palmer Gent 1327 Prestman St.

15

Filed

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/1 1922

17

I HEREBY CERTIFY, That I attended deceased from

10/25, 1922, to 11/1, 1922,

that I last saw him alive on 11/1, 1922,

and that death occurred, on the date stated above, at 5:40 p.m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

B. H. H. H.

M. D.

11/1, 1922 (Address) 2154 St. 4

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Cemetery

November 1922

20 UNDERTAKER

ADDRESS 1725

Mrs Robert A Elliott

Ashland

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCASION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCASION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D. 68922

Form 1135
6-9-1921 H. P. Co. - 1000 Bks.

113 **D. 68923**
HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 St Joseph ST.; 8 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Stanton

(a) RESIDENCE. NO. 1627 St Joseph ST., _____ WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female **4 COLOR OR RACE** col **5 Single, Married, Widowed, or Divorced (write the word)** Single
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____
6 DATE OF BIRTH (month, day, and year) Jan 1-1922
7 AGE Years _____ Months 10 Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Baeto Md
(State or country)

10 NAME OF FATHER John Stanton
11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)
12 MAIDEN NAME OF MOTHER Celia Logan
13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant John M. Stanton
(Address) 1627 St Joseph St

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1 19 22
17 I HEREBY CERTIFY, That I attended deceased from Oct 30, 19 22, to Nov 1, 19 22, that I last saw her alive on Nov 1, 19 22, and that death occurred, on the date stated above, at 10:50 p.m.
The CAUSE OF DEATH* was as follows:

Acute Milk Infection
(duration) _____ yrs. 30 mos. _____ ds.

CONTRIBUTORY (Secondary) _____ (duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____
(Signed) Walter H. White, M. D.
10/2, 1922 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery **DATE OF BURIAL** Nov 4 19 22

20 UNDERTAKER Mrs Robert A Elliot **ADDRESS** 1723 Ashland

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSE OF DEATH is very important. See instructions on back of certificates.

OV 4 - 1922

Burial Permit Clerk

20.68924 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68924

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 McCulloh ST.; 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1823 McCulloh St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Male

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

Feb 20th 1872
(Month) (Day) (Year)

7-AGE,

50 yrs. 8 mos. 12 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Clerk.

9-BIRTHPLACE, (State or Country),

Va

10-NAME OF FATHER,

George Rich.

11-BIRTHPLACE OF FATHER (State or Country),

Va

12-MAIDEN NAME OF MOTHER

Elizabeth Montague

13-BIRTHPLACE OF MOTHER (State or Country),

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov 1st 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Oct 7th 1922, to Nov 1st 1922, that I saw him alive on Oct 29th 1922, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

CONTRIBUTORY. (Duration) 2 hrs. Diabetes Mellitus (Secondary) Not known (Signed) Harry F. Brown, M. D. Nov 2nd 1922 (Address) 1501 Presbman

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

Nov 4, 1922

20-UNDERTAKER

John H. Treadwell

ADDRESS

142 W Hill St

CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dl. 68925

Dl. 68925

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Druid Hill Ave. St. 14 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1421 Druid Hill Ave. St. 31 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH,

(Month) Aug. (Day) 4, (Year) 1870

7-AGE,

52 yrs. 2 mos. 29 ds.

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Domestic at home

9-BIRTHPLACE, (State or Country),

W. Va.

10-NAME OF FATHER,

Leonard L. Veselle

11-BIRTHPLACE OF FATHER (State or Country),

W. Va.

12-MAIDEN NAME OF MOTHER

Mary Brown

13-BIRTHPLACE OF MOTHER (State or Country),

W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Blanche Kent-Harrod

(Address)

1421 Druid Hill Ave.

15-

Filed

-1922

Robert P. HAYES

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) Nov. (Day) 2, (Year) 1922

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 1 1922 to Nov. 2 1922,that I saw him alive on Nov. 2 1922,and that death occurred, on the date stated above, at 1207 m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatationPneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Adema

(Duration) yrs. mos. ds.

(Signed) W. S. Carr, M. D., 1922 (Address) 575 Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

Mt. Auburn Cemetery

DATE OF BURIAL

Nov. 15, 1922

20-UNDERTAKER

Jas. M. Johnson

ADDRESS

1234 Eeling St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Enter on back of certificate. See instructions on back of certificate.

10.68926 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68926

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 921 Cathedral ST., 11 WARD)

2. FULL NAME

(a) RESIDENCE NO. 921 Cathedral

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7th Sept. 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74 years 11 months 27 days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

County Coram Ireland

10 NAME OF FATHER

John O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Anne Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Enagh Ireland

14

Informant

(Address)

ella L. O'Neill 921 Cathedral St

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/3/22

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 22, 1922, to Nov 3, 1922.

that I last saw him alive on Nov 3, 1922.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis +

arteriosclerosis with

hypertension (duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

trauma (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Laboratory

(Signed)

J. S. Quinn M. D.

11/3/22 (Address)

804 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cemetery

DATE OF BURIAL

11/6, 1922

20 UNDERTAKER

Henry W. Mears & Son 805 N. Calvert

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

4-1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Johns Hopkins Hospital* ST. *9* WARD)2-FULL NAME *Mrs. Laura Alexander*(a) RESIDENCE NO. *New Bloomfield* ST. *Ta.* WARD *Ta.*

(Usual place of abode)

Length of residence in city or town where death occurred yrs. *2* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Widow of*6 DATE OF BIRTH (month, day, and year) *May 11, 1854*7 AGE Years *68* Months *3* Days *22* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*(b) General nature of industry, business, or establishment in which employed (or employer) *0*(c) Name of employer *0*9 BIRTHPLACE (city or town) *Pennsylvania* (State or country)10 NAME OF FATHER *Jacob Shirley*11 BIRTHPLACE OF FATHER (city or town) *Pennsylvania* (State or country)12 MAIDEN NAME OF MOTHER *Caroline Emerick*13 BIRTHPLACE OF MOTHER (city or town) *Pennsylvania* (State or country)

14

Informant (Address) *Johns Hopkins Hospital**Robert F. Harrison*

19

Registrar

Barclay Peratt Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *11 / 3* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Oct. 1*, 19*22*, to *Nov. 3*, 19*22*. that I last saw him alive on *Nov. 3*, 19*22* and that death occurred, on the date stated above, at *10:00 p.m.*

The CAUSE OF DEATH* was as follows:

Cerebral vascular accident (apoplexy) — due to arterio-sclerosis and hypertension (duration) several years ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *Yes*

What test confirmed diagnosis?

(Signed) *Lawrence S. Kubie, M. D.*Nov. 4, 1922 (Address) *Johns Hopkins Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *NEW PORT to Pennsylvania*

DATE OF BURIAL

11 / 4 / 22

20 UNDERTAKER

H. E. Hughes 424 N. Broadway

Exact statement of cause of death should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

V 4

1922

20.68928 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68928 161-002 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 422 W. Kewwood ST. 161 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry M. Ruhl

(a) RESIDENCE. NO. 422 W. Kewwood ST. 161 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3 - 22

7 AGE Years Months Days If LESS than 1 day, 1 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt.

10 NAME OF FATHER Harry M. Ruhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Maudie Ruhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt.

PARENTS

14 Informant (Address) Harry M. Ruhl 422 W. Kewwood St.

15 Filed Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 3, 1922, to Nov 3, 1922,

that I last saw him alive on Nov 3, 1922,

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Brach Rupture & Edema of lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Deary

19 Address 1600 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cem.

11/4 1922

20 UNDERTAKER

Philip Herwig

ADDRESS 2016

Oleum

tion should be carefully supplied. Avoid should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

OV 4-1922

20.68929

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.68929

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 S. 4thST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Geo. M. Bartell

(a) RESIDENCE NO.

315 S. 4th

ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yrs.

mos.

27 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 7-21

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.127

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)City

10 NAME OF FATHER

John Bartell11 BIRTHPLACE OF FATHER (city or town)
(State or country)Md.

12 MAIDEN NAME OF MOTHER

Annie Schmiga13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Md.

14

Informant
(Address)Annie Bartell
315 S. 4th St.

15

Filed

19

Robert F. Harrison

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 14, 1922, to Nov 3, 1922,that I last saw him alive on 11 " 1922,and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Yeast's Encephalitis(duration) yrs. 1 mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

GeoDid an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? clinical(Signed) A. C. Koser, M. D.14, 1922 (Address) 2600 E. Chas. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Schwartz Lem11/6 1922

20 UNDERTAKER

ADDRESS

Philip Hennig2016 Orleans

Exact statement of OCCURRENCE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

OV 4-1922

Burial Permit Clerk

D.68930 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68930

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Baker ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE NO. 611 Baker

ST. 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 6 mos. 15 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female white Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Christian Warner

6 DATE OF BIRTH (month, day, and year)

Apr 18-1843

7 AGE 79

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2nd 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30, 1922, to Nov 2, 1922.

that I last saw he alive on Nov 2, 1922.

and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

13, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Cemetery Nov. 6-1922

20 UNDERTAKER

ADDRESS

Geo. Weber & Son 2503 Calmar Ave.

Exact statement of OCCURRENCE should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

V 4-1922

20.68931 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68931

1-PLACE OF DEATH

CITY OF BALTIMORE

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence (in city or town where death occurred)

CERTIFICATE OF DEATH

ST. 15 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Robert P. Harrison,

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from Feb. 26, 1921 to Oct 31, 1922

that I last saw him alive on Oct 30, 1922

and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Uterus)

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

11/3/22 Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Exact statement of OCCUR-
rence should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

V 4

1922

Exact statement of OCCUPATION should be supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks. (Lomas) ✓
 dl. 68932 HEALTH DEPARTMENT—CITY OF BALTIMORE dl. 68932
 65-002
 CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

St. Joseph's Hospital

ST.,

WARD) 18

2-FULL NAME

Thomas Lomas

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

410 Fremont Ave.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

James Lomas

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Cecil Co Va

12 MAIDEN NAME OF MOTHER

Sarah Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Prince Georges Md

14

Informant (Address)

Carrie Henderson
1621 Bruce St

15 Filed

Robert P. Kettibol

19

Registrar

Serial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 17, 1922, to Nov. 2, 1922.

that I last saw him alive on Nov. 2, 1922.

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency
due to Pulmonary hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Hodgkin's disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

J. J. Krager M. D.

(Address)

St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Mt Auburn

Nov 4 1922

20 UNDERTAKER

Edward Ruggold 1463 Ave

10.68933 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68933

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 Federal ST.: 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura D. Bauer.

(a) RESIDENCE, NO. 1700 Federal ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 10 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1

3

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

George Bauer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Balto. Md

12 MAIDEN NAME OF MOTHER

M. Shaney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant (Address)

George Bauer, 1300 E. Federal St

15

Robert P. Harrison, Registrar

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 2 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 30, 1922, to Nov 2, 1922

that I last saw him alive on Nov 2, 1922

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Anderson, M. D.

19 (Address) 1714 N. Carroll St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mount Carmel Cemetery 11/6 1922

20 UNDERTAKER

ADDRESS

George J. Rath 1714 N. Carroll St

Information should be carefully supplied. None should be omitted. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

10-1922

Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

968934

HEALTH DEPARTMENT—CITY OF BALTIMORE

968934

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. 13 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

18 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9-BIRTHPLACE,
(State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

NOV 5 - 1922

ROBERT R. KRAUTER,

Filed

101

Bureau of Health

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by such inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY
(Secondary)

(Signed) J. H. Brown, D. (Coroner.)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?...

Former or usual residence...

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

Information should be carefully supplied. NO. should be stated on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

968935

HEALTH DEPARTMENT—CITY OF BALTIMORE

968935

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1619 Fulton ave. ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Watkins

(a) RESIDENCE. No. 1619 Fulton ave. (Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Watkins
6 DATE OF BIRTH (month, day, and year) Oct. 6 1832
7 AGE Years 90 Months Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Va.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14 Informant Mrs. E. P. Dietrich (Address) 1619 N. Fulton ave.

15 NOV 5 - 1922

ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1922 to Nov 3, 1922, that I last saw him alive on Nov 3, 1922, and that death occurred, on the date stated above, at 3-30 P.m.

The CAUSE OF DEATH* was as follows:

Artero-Sclerosis

(duration) 2 yrs. mos. ds. CONTRIBUTORY (Secondary) Fracture of hip consequent to fall (duration) 4 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? None (Signed) J. H. Hester, M. D. 19 (Address) 2008 Euter Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Onancock Va. Nov. 5 1922

20 UNDERTAKER ADDRESS Wm C. Black 927 N Broadway

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates.

968936 HEALTH DEPARTMENT—CITY OF BALTIMORE 968936

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *John Hopkins Hospital* ST., *15* WARD)

2-FULL NAME

Elena Jessie Dantes

(a) RESIDENCE NO.

2909 Chelsea Terrace

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 11, 1892

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*30**3**22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

no occupation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maine - U.S.A.

10 NAME OF FATHER

Elmer A. Dantes

11 BIRTHPLACE OF FATHER (city or town)

Mansfield

(State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Dodge

13 BIRTHPLACE OF MOTHER (city or town)

Maine

(State or country)

14

Informant (Address)

John Hopkins Hospital

15

*NOV 5 - 1922**ROBERT R. KRAUTER*

Registrar

Burial Permit Clerk.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 3rd 1922

17

I HEREBY CERTIFY, That I attended deceased from

*August 18, 1922, to Nov 3, 1922,*that I last saw her alive on *Nov 3, 1922,*and that death occurred, on the date stated above, at *6:30 P. M.*

The CAUSE OF DEATH* was as follows: -

Lung abscess

(duration)

yrs. *2* mos. ds.CONTRIBUTORY - *Pneumonia Tbc. and*

(Secondary)

Staph.

(duration)

yrs. *3* mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *X Ray of Chest*

(Signed)

Dr. J. Allen, M. D.

, 19

(Address)

John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Druid Ridge Cem.**Nov 6 1922*

20 UNDERTAKER

ADDRESS *8944**Harry W. Ehlert*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 Silsa Ave. ST. 27 WARD)

2. FULL NAME

John H. Lohmeyer

(a) RESIDENCE NO.

119 Silsa Ave

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds.

ST.,

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Sabina Lohmeyer6 DATE OF BIRTH (month, day, and year) Nov. 21st 1842

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

79 11 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Lohmeyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER

Catherine Wallich

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Sabina Lohmeyer
119 Silsa Ave

15

NOV 5 - 1922ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 2nd 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1922, to Nov 2, 1922.that I last saw h. alive on Nov 2, 1922.and that death occurred, on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Exhaustion & Pulmonary
oedema

(duration) yrs. mos. ds.

CONTRIBUTORY

(Secondary)

Myocarditis & Angina

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

3, 1922 (Address)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park CemeteryNov. 6th 1922

20 UNDERTAKER

ADDRESS

Mrs. John H. Diefel & Son801 N. FayetteExact statement of OCCUR-
rence of DEATH in plain terms, so that it may be properly classified.
CAUSE OF DEATH is very important. See instructions on back of certificates.

Exact statement of OCCASION should be supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

68938 HEALTH DEPARTMENT—CITY OF BALTIMORE 99-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 2020 E-Farmont ST., 6 WARD)

2-FULL NAME Hyman Freedman

(a) RESIDENCE NO. 2020 E-Farmont ST., 6 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 20 yrs. 0 mos. 0 ds.

REGISTERED NO. 99-001
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS					MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced, (write the word) <u>Widowed</u>			16 DATE OF DEATH (month, day, and year) <u>11/3/22</u> 19 <u>22</u>	
5a If married (widowed, or divorced) HUSBAND of (or) WIFE of _____					17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 1</u> , 19 <u>22</u> , to <u>Nov 3</u> , 19 <u>22</u> , that I last saw him alive on <u>Nov 3</u> , 19 <u>22</u> , and that death occurred, on the date stated above, at <u>1 P</u> m.	
6 DATE OF BIRTH (month, day, and year) <u>1842</u>					The CAUSE OF DEATH* was as follows: <u>Ac Cordize deb</u>	
7 AGE Years <u>80</u> Months <u>—</u> Days <u>—</u> If LESS than 1 day, <u>—</u> hrs. or <u>—</u> min.					(duration) <u>2</u> yrs. <u>0</u> mos. <u>0</u> ds.	
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <u>Tailor</u> <u>80</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____ (c) Name of employer _____					CONTRIBUTORY (Secondary) <u>Capillary Bronchitis</u> (duration) <u>2</u> yrs. <u>0</u> mos. <u>0</u> ds.	
9 BIRTHPLACE (city or town) (State or country) <u>Russia</u>					18 Where was disease contracted if not at place of death? _____	
10 NAME OF FATHER <u>Unknown</u>					Did an operation precede death? <u>No</u> Date of _____	
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>Russia</u>					Was there an autopsy? <u>No</u>	
12 MAIDEN NAME OF MOTHER <u>Unknown</u>					What test confirmed diagnosis? <u>Clinical</u>	
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Russia</u>					(Signed) <u>Myron</u> M. D. <u>11/4</u> , 19 <u>22</u> (Address) <u>110 W. 1st St.</u>	
14 Informant (Address) <u>Jack Lewis 1439 E. Balto</u>					*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)	
15 <u>NOV 5 - 1922</u> <u>ROBERT R. KRAUTER</u> Burial Permit Clerk					19 PLACE OF BURIAL, CREMATION OR RE-MOVAL <u>Heaven Road</u> <u>11/5</u> 19 <u>22</u>	
					20 UNDERTAKER <u>Jack Lewis 1439 E. Balto</u>	

068939 HEALTH DEPARTMENT—CITY OF BALTIMORE 068939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 118 Franklin ST., 4 WARD)

2-FULL NAME Francis P. Sweeney

(a) RESIDENCE NO. 118 Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Sweeney

6 DATE OF BIRTH (month, day, and year) June-1865

7 AGE Years 57 Months 6 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant

(b) General nature of industry, business, or establishment in which employed (or employer) Prop.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Patrick Sweeney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill.

12 MAIDEN NAME OF MOTHER Cath. Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ill.

14 Informant Mary H. Sweeney (Address) 118 Franklin St.

15 NOV 5-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1922

17 HEREBY CERTIFY, That I attended deceased from April 9, 1922, to Nov. 2, 1922, that I last saw him alive on Nov. 2, 1922,

and that death occurred, on the date stated above, at 12-08 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

11-5, 1922 (Address) 120 Airguth St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL

Catholic

20 UNDERTAKER

J. A. Moran

DATE OF BURIAL

11/6/1922

ADDRESS 300

E. B. Bittick

Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

68940

HEALTH DEPARTMENT—CITY OF BALTIMORE

68940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Ag. Hospital 25* St. *25* Ward)

Registered No. C. *188-103*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Thomas J. Marney*

(Residence in Baltimore: No. *13th & Heikimer* St.; yrs., *20* mos., *20* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE *White*

5-Single, Married, Widowed, *Married*
(Write the word.)

6-DATE OF BIRTH *March 17 1869*

(Month) (Day) (Year)

7-AGE *53*

yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession or particular kind of work *Laborer*
(b) General nature of industry, business, or establishment in which employed (or employer) *Wilson + Martin*

9-BIRTH (State or Country) *England*

10-NAME OF FATHER *John Marney*

11-BIRTHPLACE OF FATHER (State or Country) *Ireland*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER (State or Country) *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Jennie Marney*

(Address) *13th & Heikimer*

NOV 5-1922

ROBERT R. KRAUTER,

Filed

192

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Nov 3 1922*

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, Autopsy or Inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or Inquiry.) and that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart attack
acute coronary
(Duration) yrs. mos. *2 mos.*

CONTRIBUTORY (Secondary) *Shock*

(Duration) yrs. mos. *2 mos.*
(Signed) *Geo. C. Blodgett* M. D.
(Coroner) *Nov 3 1922*
(Address) *434 3rd Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL *Cathedral*

DATE OF BURIAL *Nov 7 1922*

20-UNDERTAKER *Wm. Cook*

ADDRESS *502 E. North*

N. B.—Every item of information on this certificate is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST., WARD.

Length of residence in city or town where death occurred

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

September 21, 1922, to November 3, 1922,

that I last saw him alive on November 1, 1922,

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) J. W. Keown, M. D.

3/1/1922 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

11/6 1922

20 UNDERTAKER

ADDRESS

Wm Coofe

502 E. North

NOV 5 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *1628 E. Monument* ST.: *7* WARD)2-FULL NAME *George N. Harold*(a) RESIDENCE. NO. *1628 E. Monument* ST.: *7* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *71* yrs. *10* mos. *9* ds.

How long in U. S. If of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widowed</i>
----------------------	---------------------------------	--

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Dec. 24, 1851*

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
<i>70</i>	<i>4</i>	<i>10</i>	<i>9</i>	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Paperhanger*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer *No employment*9 BIRTHPLACE (city or town) *Balto Md*
(State or country)10 NAME OF FATHER *Anthony Harold*11 BIRTHPLACE OF FATHER (city or town) *Bermary*
(State or country)12 MAIDEN NAME OF MOTHER *Mary Ann Stehler*13 BIRTHPLACE OF MOTHER (city or town) *Germany*
(State or country)14 Informant *George M. Harold*
(Address) *2736 E. Baltimore*15 *NOV 5 - 1922* *ROBERT R. KRAUTER*
Burlal Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 3 1922*17 I HEREBY CERTIFY, That I attended deceased from *Sept 1*, 19*22*, to *Nov. 3*, 19*22*.that I last saw him alive on *Nov. 3*, 19*22*.and that death occurred, on the date stated above, at *5:15 P* m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Larynx(duration) yrs. *10* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *JM Delivette* M. D.Address *621 Washington Boulevard*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*New Cathedral**Nov 6 1922*

20 UNDERTAKER

ADDRESS

*Wendell Wiffel Son**378 Ave*

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Bks.
mation should be carefully supplied. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important.

Mary J. Bagby ✓ *968943*
HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH

1-PLACE OF DEATH *University Hospital* ST. *4* WARD *98*
CITY OF BALTIMORE: (No. _____)
2-FULL NAME *Mary J. Bagby*
(a) RESIDENCE No. *510 S Pulaski St* ST. _____ WARD *Ashland 9a*
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. _____ mos. *10* ds. How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced (write the word) <i>Widow</i>		
5a If married, widowed, or divorced HUSBAND of <i>W. F. Bagby</i> (or) WIFE of _____				
6 DATE OF BIRTH (month, day, and year) <i>?</i>				
7 AGE <i>59</i>	Years	Months	Days	If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <i>House work</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>037</i> (c) Name of employer				
9 BIRTHPLACE (city or town) <i>Virginia</i> (State or country)				
10 NAME OF FATHER <i>W. W. Griffith</i>				
11 BIRTHPLACE OF FATHER (city or town) <i>Va</i> (State or country)				
12 MAIDEN NAME OF MOTHER <i>Mary E. Good</i>				
13 BIRTHPLACE OF MOTHER (city or town) <i>Va.</i> (State or country)				
14 Informant <i>Hospital Records</i> (Address)				

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH (month, day, and year) <i>11-4-22</i>	19
17 I HEREBY CERTIFY, That I attended deceased from <i>10-27-22</i> , 19____, to <i>11-4-22</i> , 19____, that I last saw her alive on <i>11-4-22</i> , 19____, and that death occurred, on the date stated above, at <i>9 24 P</i> m.	
The CAUSE OF DEATH* was as follows: <i>Papilloma of larynx</i>	
(duration) <i>?</i> yrs. _____ mos. _____ ds.	
CONTRIBUTORY <i>Broncho pneumonia</i> (Secondary) (duration) yrs. _____ mos. <i>1</i> ds.	
18 Where was disease contracted <i>?</i> if not at place of death?	
Did an operation precede death? <i>Yes</i> Date of <i>11-27-22</i>	
Was there an autopsy? <i>No</i>	
What test confirmed diagnosis? <i>Routine</i>	
(Signed) <i>J. R. O'Rourke</i> M. D.	
19 (Address) <i>University Hospital</i>	
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)	
19 PLACE OF BURIAL, CREMATION OR REMOVAL <i>Ashland Va</i>	DATE OF BURIAL <i>Nov 5 1922</i>
20 UNDERTAKER <i>Harry H. Witzke</i>	ADDRESS <i>1531 W. Lombard</i>

15 *NOV 5-1922* ROBERT R. KRAUTER
Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

268944

HEALTH DEPARTMENT—CITY OF BALTIMORE

268944

CERTIFICATE OF DEATH.

PLACE OF DEATH

CITY OF BALTIMORE (No. 2529 Barclay

2-FULL NAME Mary Shortt

(Residence in Baltimore: No. 2529 Barclay

REGISTERED No. C

ST. 12 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

28. yrs., 2 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, August 14, 1894 (Month) (Day) (Year)

7-AGE, 28 yrs., 2 mos., 6 ds. If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, House-wife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, August Otter

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Annie B. Fickenscher

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie B. Otter (Mother)

(Address) 208 E. Montgomery St.

15-

NOV 5 - 1922 101. ROBERT R. KRAUTER, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 3, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held inquest, and from the evidence obtained by autopsy and from the evidence obtained by inquest, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: *Salmonella* of Heart (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. ... ds.

(Signed) *John F. Denny* M. D. 3632 R. E. Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery DATE OF BURIAL, Nov 6, 1922

20-UNDERTAKER, John F. Denny ADDRESS, 715 Light St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4 WARD)

2-FULL NAME

(a) RESIDENCE. NO. Paradise, Md. ST. 4 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 16 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Geot. Roles

6 DATE OF BIRTH (month, day, and year)

Feb 5 1873

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

49

8

30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Alec Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14 Informant (Address)

Hospital Records

15 NOV 5 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4 1922

17 I HEREBY CERTIFY, That I attended deceased from October 19, 1922 to November 4, 1922 that I last saw him alive on Nov. 4, 1922 and that death occurred, on the date stated above, at 3:00 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma large intestine

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted? home If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

When test confirmed diagnosis? Histology Lab & E. C. Hall, M. D.

(Signed) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Bever Hill Cemetery

20 UNDERTAKER

John H. Denny

DATE OF BURIAL

Nov 7 1922

ADDRESS

715 Light St

N. B.—WRITE PLAINLY, WITH CAPITAL LETTERS. PHYSICIAN SHOULD BE STATED EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Volunteers of America Hospital* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas W. Wall

(a) RESIDENCE

No. *1135 Nanticoke* ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

m

4 COLOR OR RACE

w

5 Single, Married, Widowed, or Divorced (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Catherine E. Wall

6 DATE OF BIRTH (month, day, and year)

April 24, 1874

7 AGE

Years *48*Months *6*Days *10*

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Glass Blower

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

Patrick Wall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mahler Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14 Informant (Address)

Catherine E. Wall 1135 Nanticoke St.

15

NOV 5-1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 3 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*Sept 27, 1922, to Nov 3, 1922*that I last saw him alive on *Nov 3, 1922*and that death occurred, on the date stated above, at *11:45 a.m.*

The CAUSE OF DEATH* was as follows:

Appendicitis. Patient operated on for ruptured appendix, Sept 27, 1922.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*at home*Did an operation precede death? *yes* Date of *Sept 27*Was there an autopsy? *no*What test confirmed diagnosis? *operation*(Signed) *Albert J. Conway, M. D.*, 19 (Address) *Vol. of Am. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Int. Olivet Cemetery, Room 6, 1922

20 UNDERTAKER

ADDRESS

George Smith 1533 Holling St.

N. B.—WRITE PLAINLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

068947 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1846 W. Santiago ST.: 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1846 W. Santiago St. 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,hrs. or....min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant),

(Address),

15-

Filed

101

ROBERT D. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov 4, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 1916, to Nov 4 1922,

that I saw her alive on Nov 4 1922, and that death occurred, on the date stated above, at 1155 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 6 yrs.mos.ds.

CONTRIBUTORY (Secondary)

(Duration)yrs.mos.ds.

(Signed) Chas. A. Schaefer M. D.

Nov 5, 1922 (Address) 53 S. Fulton St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D 68948

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3500 Pk. Heights Ave. ST., 15 WARD)

2. FULL NAME

John W. Buck

(a) RESIDENCE NO.

3500 Pk. Heights Ave. ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

30

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Sarah B. Buck

6 DATE OF BIRTH (month, day, and year) Feb. 6" 1845

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

77

8

27

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Montoursville, Lycoming
Pa.

10 NAME OF FATHER

Israel D. Buck

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Margaret Couden

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Pa.

14

Informant
(Address)

Hiram M. Buck

30 Church St., New York

15

NOV 5-1922

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3" 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Aug 22, 19 22, to Nov 3, 19 22,
that last saw him alive on November 3rd, 19 22

and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic EndocarditisCONTRIBUTORY (duration) yrs. 3 mos. ds.
Acute Cardiac Disturbance
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death? Do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Chas B Riemann, M. D.

11/4 19 22 Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

MOVIAL Williamsport, Pa. Nov. 6, 22

20 UNDERTAKER ADDRESS

Joseph B. Cook 1003 1/2 E. Baltimore St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D68949 HEALTH DEPARTMENT—CITY OF BALTIMORE D68949

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 809 Union Ave. St. 13 WARD)
2-FULL NAME William H. Molesworth
(Residence in Baltimore: No. 809 Union Ave. St. 20 rs., - mos. - ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male
4-COLOR OR RACE White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
6-DATE OF BIRTH, Oct. 2, 1864
(Month) (Day) (Year)

7-AGE, 58 yrs., 1 mos., 1 ds.
IF LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Engineer B. ORR
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 3 years

9-BIRTHPLACE (State or Country) Baltimore Co. Md.

10-NAME OF FATHER Asbury Molesworth

11-BIRTHPLACE OF FATHER (State or Country) Frederick Co. Md.

12-MAIDEN NAME OF MOTHER Elizabeth Ditty

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Sarah C. Molesworth
(Address) 809 Union Ave.

15- NOV 5 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH November 3, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, autopsy or inquiry thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Coronary disease of heart.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. H. M. D.
(Coroner) 1912- (Address) 3632 Rockwell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, Nov 6, 1922

20-UNDERTAKER, ADDRESS Horace H. Burgee 3631 Falls Road

D68950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68950

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Univ. Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Hattie Garrett,

(a) RESIDENCE. NO.

522 N. Gilman St.,

ST.,

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (Write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

✓

6 DATE OF BIRTH (month, day, and year)

1889

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

33

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laurel House work and

(b) General nature of industry, business, or establishment in which employed (or employer)

(House)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

H. C.

10 NAME OF FATHER

J. M. Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

H. C.

12 MAIDEN NAME OF MOTHER

A. W. Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

H. C.

14

Informant (Address)

Hospital Records

15

Filed

19

NOV 5 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 1 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1922, to Nov. 1, 1922, that I last saw her alive on Oct. 31, 1922, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Hyperemesis gravidarum

2 wks.

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

✓

Did an operation precede death? yes

Date of

Oct. 31/22

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

W. H. Hester

M. D.

19

(Address)

Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt Auburn Cem.

Nov 5 22

20 UNDERTAKER

ADDRESS

R. L. Gross 1408 McElenny

mation should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE IN PLAIN TERMS. Information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 Right ST. 24 WARD)

2-FULL NAME

Bridget Mary McCall

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1707 Right ST. 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds.How long in U. S., if of foreign birth? yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick F. McCall6 DATE OF BIRTH (month, day, and year) May 11, 18427 AGE Years 80 Months 5 Days 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland10 NAME OF FATHER Bernard McCloskey11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland12 MAIDEN NAME OF MOTHER Glenn Keerney13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland14 Informant Miss Sarah McCall (Address) 1707 Right St.15 NOV 5 - 1922 ROBERT R. KRAUTER RegistrarBurial Permit 1422

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 192217 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to Nov 3, 1922.that I last saw him alive on Nov 2, 1922.and that death occurred, on the date stated above, at 10.4 m.

The CAUSE OF DEATH* was as follows:

apoplexy. Cerebral.(duration) yrs. 3 mos. 3 ds.CONTRIBUTORY Chronic Bronchitis (Secondary)(duration) yrs. 6 mos. 0 ds.18 Where was disease contracted if not at place of death? 2Did an operation precede death? No Date of —Was there an autopsy? NoWhat test confirmed diagnosis? Sudden death - Paralysis (Signed) Chas. O'Donnell M. D.Address 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cathedral Cem.

20 UNDERTAKER

Margaret S. Flynn

DATE OF BURIAL

Nov 6, 1922

ADDRESS

1422 Right St.

N. B.—Every item of information should be carefully checked and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

68952

HEALTH DEPARTMENT—CITY OF BALTIMORE

68952

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. *27* St. *27* Ward)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Joseph C. Cael

(Residence in Baltimore: No. *27 Washington St.* St.; yrs., *2* mos., *5* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Divorced* (Write the word.)

6-DATE OF BIRTH, (Month) *1* (Day) *1* (Year) *1922*

7-AGE, *41* yrs., *1* mos., *5* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Home Manager* (b) General nature of industry, business, or establishment in which employed (or employer), *86*

9-BIRTHPLACE, (State or Country), *MD*

PARENTS. 10-NAME OF FATHER, *John L. Cael* 11-BIRTHPLACE OF FATHER, (State or Country), *MD* 12-MAIDEN NAME OF MOTHER, *May Shook* 13-BIRTHPLACE OF MOTHER, (State or Country), *MD*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John L. Cael* (Address) *27 Washington St.*

15- *NOV 5 - 1922* ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) *Nov* (Day) *3* (Year) *1922*

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows: *Fractured Skull* (Duration) *1* yrs., *1* mos., *5* ds.

CONTRIBUTORY (Secondary) *Fall from house* (Duration) *1* yrs., *1* mos., *5* ds. (Signed) *W. H. Young* M. D. (Coroner.) 11-44 1922 (Address) *1318 Legal*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *St Marys Borans 11/6/22*

20-UNDERTAKER, ADDRESS *John J. Fahy, 1318 Legal*

N. B. - WRITE PLAINLY, and be careful. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

68953 HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Dorsey(a) RESIDENCE No. 155 W. Henrietta St.ST. 22 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Separated5a If married, widowed, or divorced
HUSBAND of
(or) WIFE ofNot stated6 DATE OF BIRTH (month, day, and year) 18737 AGE Years Months Days If LESS than 1 day, hrs. or min.
49

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland10 NAME OF FATHER Chas. Dorsey11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Waters13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14

Informant Hospital Records
(Address) M. T. H.

15

NOV 6 - 1922 ROBERT R. KRAUTER,
RegistrarFuneral Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3, 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct. 28, 1922 to Nov. 3, 1922.that I last saw him alive on Nov. 3, 1922.and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis(duration) Unknown yrs. mos. ds.CONTRIBUTORY Syphilis
(Secondary)(duration) Unknown yrs. mos. ds.18 Where was disease contracted
if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Dadeghacea M. D.11-3-22 (Address) Municipal Tho. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Mt. Auburn Ct.Nov 6 1922

20 UNDERTAKER

ADDRESS

S. L. Brown & Son 108 W. Monty

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 111 Glover

ST. 6

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Narek

(a) RESIDENCE. No. 111 Glover

ST. 6

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs

mos. 18

ds.

How long in U. S., if of foreign birth?

yrs

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

NOV 6 - 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct 19, 1922, to Nov 5, 1922,

that I last saw him alive on

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Birth & Gastritis

(duration)

yrs.

mos. 18

ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

1922

Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

D68956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-0

D68956

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

3618 Fruit Park Ave.

ST. 15th WARD

2-FULL NAME

Thomas Harry Mottel

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Resident

(a) RESIDENCE NO.

3618 Fruit Park Ave.

ST. 15th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 20 ds.

(If non-resident give city or town and State) How long in U. S., if of foreign birth? 67 yrs. 11 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced, HUSBAND of (or) Ellen B. Mottel

6 DATE OF BIRTH (month, day, and year) November 3-1854

7 AGE 67 Years 11 Months 20 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumber merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber

(c) Name of employer Mottel & Co.

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country) Md.

10 NAME OF FATHER Theodore Mottel

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. Md. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Kearney

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country) Md.

14 Informant (Address) Edward M. Mottel (son) 3618 Fruit Park Ave.

15 NOV 6-1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov-3-1922

17 I HEREBY CERTIFY, That I attended deceased from 10-29, 1922, to 11-3, 1922,

that I last saw him alive on 11-3, 1922,

and that death occurred, on the date stated above, at 12-15 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. ds.

CONTRIBUTORY Robert Pneumonia (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur R. Schaeffer, M. D.

13, 1922 (Address) 2806 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Linden Park Cemetery

20 UNDERTAKER STEWART & MOWEN COMPANY

(WILLIAM F. WOODEN, Successor)

DATE OF BURIAL

Nov 6-1922

ADDRESS

108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH CARE. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

968957 HEALTH DEPARTMENT—CITY OF BALTIMORE 968957

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Edgewood Sanatorium* ST., *12* WARD)

2-FULL NAME

Margaret Bayley Bride

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

*2934 N. Calvert*ST., *12* WARD*Resident*

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *68* yrs. *11* mos. *4* ds. How long in U. S., if of foreign birth? *68* yrs. *11* mos. *4* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year)

Dec-1-1853

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*68**11**4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

none

(c) Name of employer

none

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Cotter Bride

PARENTS

11 BIRTHPLACE OF FATHER (city or town) (State or country)

not known
Ireland

12 MAIDEN NAME OF MOTHER

Mary Bayley

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

not known
England

14

Informant (Address)

Mrs Catherine A. Pearce (sister)
2934 N. Calvert St.

15

Filed

NOV 6 - 1922

ROBERT R. KRAUTER,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 5* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Jan. 1*, 19*22*, to *Nov. 5*, 19*22*, that I last saw her alive on *Nov. 4*, 19*22*, and that death occurred, on the date stated above, at *2 A.* m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis(duration) *1* yrs. *1* mos. *14* ds.CONTRIBUTORY *Bronchopneumonia* (Secondary)(duration) *1* yrs. *1* mos. *14* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Chronic*(Signed) *H. C. Hens*, M. D.*Nov 5 1922* (Address) *5600 York Road.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Freemount Cemetery

DATE OF BURIAL

Nov 7 1922

20 UNDERTAKER

STEWART & MOWEN COMPANY

ADDRESS

103 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH CARE. Information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (Not for use in rural areas)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant
(Address)

15

NOV 6 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from
Oct 27 - 1922, to Nov 4, 1922.

that I last saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Diarrhoea (Not Dysentery)

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 BURIAL

ADDRESS

N.B.—WRITE FULL NAME, AGE, should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D68959

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68959

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Lambert

ST. 17

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Sarah Dorcus

(Residence in Baltimore: No. 520 Lambert

St.: 26 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)

Married

6-DATE OF BIRTH,

2

2

1871.

(Month)

(Day)

(Year)

7-AGE,

57

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer).

House wife

9-BIRTHPLACE,

(State or Country),

Md

PARENTS.

10-NAME OF FATHER,

John Matthews

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Annie Cure

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Matthews

(Address) 520 Lambert St

15-

Filed

NOV 6 - 1922

191

ROBERT R. KRAUTER,

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov

2

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct. 17th 1922

to

Nov. 2 1922

that I saw him alive on Nov. 2 1922

and that death occurred, on the date stated above, at 9:10 p.m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. L. E. M. D.

11-3-1922 (Address) 924 Madison Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

Mt Auburn Cemetery Nov 6 1922

20-UNDERTAKER

ADDRESS

Daniel Taylor Dr

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION, CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH CARE. Exact statement of OCCURRENCE should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec. 1-10-21 MNT 1500 Bks.

68960 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 68960

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hosp.
CITY OF BALTIMORE: (No. Eastern Ave ST., 1 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Becker
(a) RESIDENCE NO. 2214 Boyer St. ST., WARD

(Usual place of abode)
Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS
3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Becker
6 DATE OF BIRTH (month, day, and year) 1860
7 AGE Years 62 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

10 NAME OF FATHER John Becker
11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Martha Becker
13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Hospital Records
(Address) Municipal Hosp.

15 NOV 6 - 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) 11-4 1922

17 I HEREBY CERTIFY, That I attended deceased from 11-2 1922, to 11-4 1922, that I last saw him alive on 11-4 1922, and that death occurred, on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of prostate with metastases to liver
(duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of -

Was there an autopsy? no
What test confirmed diagnosis? Examination
(Signed) Richardson M. D.
, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT
20 UNDERTAKER John Keller

DATE OF BURIAL
ADDRESS
2008 Adams

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Maryland General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

Baltimore Md. ST. 16th WARD)

2-FULL NAME

Mrs Alice Baum

(a) RESIDENCE NO.

830 Carey

ST.

North

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

23 yrs.

4 mos.

6 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Frederick K Baum

6 DATE OF BIRTH (month, day, and year)

June 27-79

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

23

4

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md.

10 NAME OF FATHER

Louis Baum

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto Md.

12 MAIDEN NAME OF MOTHER

Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto Md.

14

Informant (Address)

Albert S Baum 830 Carey St

15

NOV 6-1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 3 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 3 1922 to Nov 3 1922

that I last saw her alive on Nov 3 1922

and that death occurred, on the date stated above, at 10:30 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Surgical shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W J Coleman M. D.

19 (Address) 1111 Paul Hoapt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Green Mount bury

DATE OF BURIAL

Nov 6 1922

20 UNDERTAKER

Wm Robinson

ADDRESS

2238 W
Milton

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *955 N. Bond* ST., *7* WARD)2-FULL NAME *Della Appa. Volght*(a) RESIDENCE NO. *955 N. Bond* ST., *7* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *31* yrs. *9* mos. *18* ds.How long in U. S., if of foreign birth? *Life* yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *January 16 1891*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*31**9**18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Robert Appa

11 BIRTHPLACE OF FATHER (city or town) (State or country)

England

12 MAIDEN NAME OF MOTHER

Annie Martino

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Co. Md.

14

Informant (Address)

Mr. Annie Appa 955 N. Bond St.

15

*NOV 6 - 1922*ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *November 4 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Nov 4 1922* to *Nov 4 1922*that I last saw him alive on *Nov 4 1922*and that death occurred, on the date stated above, at *8:30 A. M.*

The CAUSE OF DEATH* was as follows:

*Tubercular Tuberculosis**Chronic & Incurable*
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Heart disease
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*London Park Cemetery**November 7 1922*

20 UNDERTAKER

ADDRESS

*Henry Hoeck Son**1301 E. Eager St.*

N. B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

WARD.

(If nonresident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

NOV 6-1922

ROBERT K. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 1, 1922, to Nov 5, 1922,

that I last saw him alive on Nov 5, 1922,

and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

68964 Mac Odren HEALTH DEPARTMENT—CITY OF BALTIMORE 68964

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 Sixth ST. 44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Mac Odren

(a) RESIDENCE. No. 28 Sixth

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Vina Mac Odren

6 DATE OF BIRTH (month, day, and year) Sept. 1 - 1871

7 AGE Years 31 Months 2 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Davis Chem. Co.

9 BIRTHPLACE (city or town) Sydney, Nati Brittan

(State or country)

Nova Scotia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Vina Mac Odren

(Address)

28 Sixth St Brooklyn

NOV 6 - 1922. 19

ROBERT R. KRAUTER,

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 3rd 1922

17 I HEREBY CERTIFY, that I attended deceased from June 29th 4, 1922, to Nov 3rd 4, 1922, that I last saw him alive on Nov. 2nd 12 P. m.

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 4 yrs. 5 mos. 5 ds. CONTRIBUTORY Cachexia (Secondary) (duration) 1 mos. 15 ds.

18 Where was disease contracted at place of death

if not at place of death? No

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? X-ray & test meals

(Signed) Harry Heibel, M. D.

11/4, 1922 Address 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

London Park Nov 6 1922

20 UNDERTAKER

ADDRESS

Josiah Sykes 1600 North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 N Vincent ST.: 19 WARD)

2-FULL NAME

(a) RESIDENCE. NO. 22 N. Vincent ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 1901

7 AGE 41 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N. C. (State or country)

10 NAME OF FATHER Allen T. Burch

11 BIRTHPLACE OF FATHER (city or town) N. C. (State or country)

12 MAIDEN NAME OF MOTHER Henry Portzif

13 BIRTHPLACE OF MOTHER (city or town) N. C. (State or country)

14 Informant (Address) William Kennedy 22 N. Vincent st.

15 Filed 6-19-22

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1922

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1922, to Nov 4, 1922, that I last saw him alive on Nov 3, 1922, and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Norwood

19 (Address) 989 N. T. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITHOUT ABRUPTNESS. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL WARD)

2-FULL NAME

Charles Bass

(a) RESIDENCE NO.

1435 Hamvale St

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 26-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

1

10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

Charles Bass

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Alabama

12 MAIDEN NAME OF MOTHER

Fannie Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Georgia

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

NOV 6-1922

ROBERT R. KRAUTER

Filed

. 19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 5-1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 21-1922, to Nov 5-1922,

that I last saw him alive on Nov. 5-1922

and that death occurred, on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 25 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed)

Horton Caspary, M. D.

. 19

(Address)

Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Woodlawn Cem

DATE OF BURIAL

Nov 6-1922

20 UNDERTAKER

Betham

ADDRESS

1723 W. 1st St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Anne's* ST. *10* WARD)

2-FULL NAME

(a) RESIDENCE NO. *735 N. Gay St.* ST. *10* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *45* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *E. J. Higgins*6 DATE OF BIRTH (month, day, and year) *June 13, 1858*7 AGE *64* years *4* months *23* days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *070*(b) General nature of industry, business, or establishment in which employed (or employer) *Domestic*

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *Morris Cushing*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ireland*12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ireland*14 Informant *Mrs. Patrick Higgins* (Address) *735 N. Gay St.*15 *ROBERT R. KRAUTER* Registrar

Filed NOV 6 - 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Oct 31* 19 *22*17 I, HEREBY CERTIFY, That I attended deceased from *Oct. 31, 1922* to *Oct 31, 1922* that I last saw *her* alive on *Oct 31, 1922*and that death occurred, on the date stated above, at *11:41* m.

The CAUSE OF DEATH* was as follows:

*Myocarditis - Chr. hyperten.
Myocardial insufficiency.**Not known* (duration) yrs. mos. ds.CONTRIBUTORY *Broncho-pneumonia* (Secondary) (duration) yrs. mos. *4* ds.18 Where was disease contracted *Home* if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *W. C. Caldwell* M. D., 19 (Address) *St. Agnes Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

*Holy Redeemer Cemetery*20 UNDERTAKER *Edmund Conklin* ADDRESS *924 E. Eager St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Hebrew Hospital

CITY OF BALTIMORE: NO.

8 Monument

ST.

WARD)

2-FULL NAME

Baby (Boy) James

(a) RESIDENCE. NO.

213 N. Belmont

ST.

WARD.

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Left

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

X

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

X

6 DATE OF BIRTH (month, day, and year)

Oct 31, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

W. R. James

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Beulah James

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Mrs. Harry James 213 N. Belmont Ave

15

NOV 6 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1922

17 I HEREBY CERTIFY, That I attended deceased from

10-31-1922, to 11-5-1922,

that I last saw him alive on 11-4-1922,

and that death occurred, on the date stated above, at 1-30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. 4

Difficult labor

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest Ballantech M. D.

11-5-1922 Address) Hebrew Hospital

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Nov 6 1922

20 UNDERTAKER ADDRESS

Mrs. C. Miller 2334 Jefferson St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 S. Wolfe ST. 2 WARD)2-FULL NAME George W. Houseman(a) RESIDENCE NO. 426 S. Wolfe ST. 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 1 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of Marie A. Houseman (or) WIFE of6 DATE OF BIRTH (month, day, and year) Sept. 7 - 18737 AGE Years 49 Months 1 Days 26 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)10 NAME OF FATHER George W. Houseman11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)12 MAIDEN NAME OF MOTHER Waltham Shaw13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)14 Informant Marie A. Houseman (Wife)(Address) 426 S. Wolfe St.15 NOV 6 - 1922 ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 2nd 192217 I HEREBY CERTIFY, That I attended deceased from 10-31-, 1922 to 11-2-, 1922 that I last saw him alive on 11-1-, 1922and that death occurred, on the date stated above, at 11:50 a. m.

The CAUSE OF DEATH* was as follows:

Gastric CarcinomaCONTRIBUTORY (Secondary) Pulmonary TB (duration) 1 yrs. 1 mos. 13 ds.18 Where was disease contracted if not at place of death? ✓Did an operation precede death? No Date of ✓Was there an autopsy? NoWhat test confirmed diagnosis? Laboratory findings(Signed) Dr. Heller M. D.(Address) 1937 Graph St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Mount Carmel Cemetery

DATE OF BURIAL

20 UNDERTAKER Lilly & Ziller

ADDRESS

403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1540 Appleton ST.; 15 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME, Vincent E. Miller
(Residence in Baltimore: No. 1540 Appleton ST. St.: 35 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE, White	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married
6-DATE OF BIRTH. 1882 (Month) (Day) (Year)		
7-AGE. 40 yrs., mos. ds. If LESS than 1 day, hrs. or min.		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Shipping clerk General Manager		
9-BIRTHPLACE. (State or Country). New Freedom Pa.		
PARENTS.	10-NAME OF FATHER. L. E. Miller	
	11-BIRTHPLACE OF FATHER (State or Country). Pa.	
	12-MAIDEN NAME OF MOTHER Mary Hessel	
	13-BIRTHPLACE OF MOTHER (State or Country). Md.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Addie Tolson
(Address) 1540 N. Appleton

15-
Filed NOV. 6 - 1922 ROBERT R. KRAUTER,
Bureau of Health Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH.
November 5th, 1912
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from
Nov. 1, 1912, to Nov. 5, 1912,
that I saw him alive on 12 midnight Nov 4,
and that death occurred, on the date stated above, at 2:30 a.m.
The CAUSE OF DEATH* was as follows:
(Lymphangitis)
Septic infection of
left hand.
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Chronic Alcoholism
(Duration) 16 yrs. mos. ds.
(Signed) Thos. H. Phillips M. D.
Nov. 1912. (Address) 2300 E. Under

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral	DATE OF BURIAL, Nov. 7, 1912
20-UNDERTAKER Marlin Baker	ADDRESS 1827 N. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of St. Per* ST. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

White

Widower

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Elizabeth Kuppel.

6 DATE OF BIRTH (month, day, and year) 29 Jan. 1843

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

79

9

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

house.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Germany.

10 NAME OF FATHER

Michael Kuppel

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ger.

12 MAIDEN NAME OF MOTHER

Mary

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ger.

14

Informant
(Address)Sister Florence
Pierce

15

Filed

NOV 6-1922

ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

No record

19

to

19

that I last saw him alive on Nov 2 1922

and that death occurred, on the date stated above, at 3:15 a.m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart

(duration)

yrs.

mos.

da.

CONTRIBUTORY
(Secondary)

Acute bronchitis

(duration)

yrs.

mos.

da.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. A. Warner, M. D.

4, 1922 (Address)

1133 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer Cem.

Nov 7 1922

20 UNDERTAKER

ADDRESS

Lilly and Zeiler

103 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

12.68973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 12 WARD)

2-FULL NAME

Alex M. Deppish

(a) RESIDENCE NO.

Unknown

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

1851

7 AGE

Years

Months

Days

71

--

--

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Municipal Hospital Records.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 19 22

17

I HEREBY CERTIFY, That I attended deceased from February 9, 19 14, to November 5, 19 22, that I last saw him alive on November 4, 19 22, and that death occurred, on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

~~Portal Cirrhosis of liver~~

CONTRIBUTORY (Secondary)

(duration)

5 yrs.

mos.

ds.

(duration)

16 yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Clyde M. Neill, M. D.

11/6/1922 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDERTAKER

St. Patrick's Cemetery
Mrs. Maude Fink

DATE OF BURIAL

11/6 19 22

ADDRESS

1737 51

B.—WRITE PLAINLY, WITH UNFADING INK. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

NOV 6 - 1922

D. 68974 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D. 68974

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1176 Leadenhall ST., 2nd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 1176 Leadenhall

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 24 1863

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

Robert P. Garrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) Nov 4th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 10, 1922, to

Nov 4, 1922.

that I last saw her alive on

Nov 4, 1922.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Myocardic Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

F. C. Smith, M. D.

11/6/22 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

1107 AM Mrs. Nottingham Rd. Nov 7th 1922

20 UNDERTAKER

ADDRESS

Joseph B Cook 1003 N. Falls St.

NOV 6-1922

Burial Permit Given

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS SHOULD BE CAREFUL TO STATE EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

10.68975 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68975

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 W. Baltimore St. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Reynolds.

(a) RESIDENCE NO. 918 W. Baltimore St. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph P. Reynolds

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1859

7 AGE Years 62 Months 10 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER John J. Hentz

11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Mullaney

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant John Hentz (Address) 853 N. Lexington St.

15 Filed 19 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 4, 1922

17 I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1922, to Nov. 4, 1922.

that I last saw her alive on " " 19 22

and that death occurred, on the date stated above, at 2.40 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Diabetes

(duration) 2 yrs. mos. ds.

CONTRIBUTORY Diabetic coma (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) George J. Reynolds, M. D.

11/4/22 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park Cemetery

DATE OF BURIAL

Nov. 7 1922

20 UNDERTAKER

Joseph B. Cook

ADDRESS

1003 W. B
Balto. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PREVIOUS STATEMENT OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.68976 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.68976

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins* St. *2129* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... *Ida Jones*

(Residence in Baltimore: No. *719* St.; yrs.,..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *white* 5-Single *Married* (Write the word.)

6-DATE OF BIRTH. *Mar* *3* *1860*
(Month) (Day) (Year)

7-AGE. *62* yrs. *7* mos. *27* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... *House Keeping*
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), *Balto*

10-NAME OF FATHER, *John Schmier*

11-BIRTHPLACE OF FATHER, (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Ida Jones*

13-BIRTHPLACE OF MOTHER, (State or Country), *Balto*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... *Johns Hopkins*

(Address).....

15-.....

1922 *Robert F. Harrison* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov* *1* *1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis - involvement of coronary arteries - Chronic Nephritis - myo-carditis
(Autopsy at *Hopkins*)..... ds.

CONTRIBUTORY (Secondary).....

(Duration)..... yrs..... mos..... ds.

(Signed) *J. S. E. North* M. D.
(Coroner.)

11-6 *1922* (Address) *J. S. E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Carmel Cemetery *11/7* *1922*

20-UNDERTAKER, ADDRESS

George J. Reith *1735 Harbor Road*

Burial Permit Blank

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.68977 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 10.68977

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 1407 E. Layfette ave. 9 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME John T. E. Lutz
(Residence in Baltimore: No. 1407 E. Layfette ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male	4-COLOR OR RACE. White	5-Single, Married, Widowed, or Divorced. Widowed
6-DATE OF BIRTH. 27 June 1896 (Month) (Day) (Year)		
7-AGE. 46 yrs. 4 mos. 9 ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). Special Agent Officer		
9-BIRTHPLACE. (State or Country). Balt.		
PARENTS.	10-NAME OF FATHER. Adam Lutz	
	11-BIRTHPLACE OF FATHER. (State or Country). Balt.	
	12-MAIDEN NAME OF MOTHER. Josephine Schroeder	
	13-BIRTHPLACE OF MOTHER. (State or Country). Balt.	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Raymond J. Lutz
(Address) 1407 E. Layfette ave.

15- Robert P. Harrison,
Filed 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov 5 1922 (Month) (Day) (Year)	17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry. thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows: Myocardia (Coronary Arteriosclerosis) (Duration) yrs. mos. ds. CONTRIBUTORY (Secondary) acute alcoholism (Duration) yrs. mos. ds. (Signed) J. S. Valler M. D. (Coroner.) 11-6 1922 (Address) 508 E. North Ave. *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. 18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence Place of removal, DATE OF BURIAL. St. Patrick's Cemetery 11/8/1922 20-UNDERTAKER, ADDRESS George J. Rutz 1735 Hayford Ave.
---	--

NOV 6 - 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

2. FULL NAME

Mr. William B. Neff

(a) RESIDENCE NO.

Gates Mills, Ohio.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of

(or) WIFE ofElizabeth H. Neff, (wife)

6 DATE OF BIRTH (month, day, and year)

April 30, 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7167

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ohio

10 NAME OF FATHER

Cornelius Neff

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ohio

12 MAIDEN NAME OF MOTHER

Liza Thinehard

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ohio

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

Robert F. Harrison

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept 7, 1922 to Nov. 6, 1922that I last saw him alive on Nov. 6, 1922and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy(duration) 17 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Broncho Pneumonia(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted

if not at place of death? HomeDid an operation precede death? yes Date of Oct 20, 1922Was there an autopsy? yesWhat test confirmed diagnosis? Autopsy(Signed) Eugene C. Shaw, M. D.19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Cleveland, Ohio 11/6/22

20 UNDERTAKER

ADDRESS

St. Elizabeth's Hosp. Cleveland, Ohio

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DL 68979 HEALTH DEPARTMENT—CITY OF BALTIMORE DL 68979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1422 Reynolds ST. WARD)

2-FULL NAME

(a) RESIDENCE NO. 1422 Reynolds ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or WIFE of Antonia Morretta

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE Years 35 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant A. Morretta (Address) 1422 Reynolds St.

15

1922

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11. 5. 1922

17 I HEREBY CERTIFY, that I attended deceased from 1922 November 8 to 1922 November 8 that I last saw him alive on 1922 November 8

and that death occurred, on the date stated above, at 4 A. M.

18 CAUSE OF DEATH was as follows: Chronic Valvular Heart Disease (Mitral)

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

11/ Signed: Dr. H. A. Meyer M. D. Address: 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Holy Cross Cem. Nov 7 1922 Margaret G. Flynn 1422 Reynolds

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.68980 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.68980
CERTIFICATE OF DEATH. 179 Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. *Mad. Gen. Hop.* St. *27* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Richard B. Spedding*
(Residence in Baltimore: No. *533 W. Wimmer* St., yrs. *1* mos. *28* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *male* 4-COLOR OR RACE *white* 5-Single, Married, Widowed, or Divorced, (Write the word) *Single*
6-DATE OF BIRTH *Sept. 6, 1904*
(Month) (Day) (Year)
7-AGE *8* yrs. *1* mos. *28* ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country) *Baltimore*
10-NAME OF FATHER *Wm. N. Spedding*
11-BIRTHPLACE OF FATHER, (State or Country) *Mad.*
12-MAIDEN NAME OF MOTHER *Minnie Cross*
13-BIRTHPLACE OF MOTHER, (State or Country) *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. N. Spedding*
(Address) *5332 Wimmer Ave.*

15- *Robert F. Harrison,*
Filed *1922* *Bureau Permit Clark.* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Nov. 4, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

1st & 2nd degree burns of face & body.
(Duration) yrs. mos. ds.
CONTRIBUTORY *playing with matches.*
(Secondary) (Duration) yrs. mos. ds.

(Signed) *J. J. Harrison,* M. D. (Coroner.)
Nov. 6, 1922 (Address) *2802 E. Lombard Ave.*
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence
19-PLACE OF BURIAL OR REMOVAL *London Park* DATE OF BURIAL *Nov. 7, 1922*
20-UNDERTAKER *Wm. J. Ryan* ADDRESS *1422 Light*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Spec. 6-9-19—H. P. Co.—1900 Bks.)

D68981

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D68981

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 226 W Hamby ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Lucy Green

(a) RESIDENCE. No. 226 W Hamby ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

Life

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fem. Col.

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Widow

6 DATE OF BIRTH (month, day, and year)

Mar - 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

md

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown

14

Informant (Address)

Hannette Green
226 W Hamby St.

15

ROBERT R. KRAUTER, Registrar

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

11/5/22

1922

17

HEREBY CERTIFY, That I attended deceased from

10/2/22 to 11/4/22

1922

that I last saw him alive on

11/4/22

1922

and that death occurred, on the date stated above, at

2:30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) about 2 yrs.

CONTRIBUTORY (Secondary)

Symptoms of Contracted Kidneys (Nephritis)

(duration) about 2 yrs.

18 Where was disease contracted if not at place of death?

none

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Microscopic clinical

(Signed)

11/6/22

19

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel St

Nov 7 - 1922

20 UNDERTAKER

ADDRESS

J. H. Brown & Son 108 W. Mount

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

6-9-19—H. P. Co.—1000 Bks.
D68982

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68982

CERTIFICATE OF DEATH.

112

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2101 Ballow ave ST. 13 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Daily

(a) RESIDENCE: NO. 2101 Ballow ave. ST. WARD. (If nonresident give city or town and State)

(Usual place of abode) Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word) 6a If married, widowed, or divorced HUSBAND of (or) WIFE of

Female White Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 84 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

House work

9 BIRTHPLACE (city or town) (State or country)

Balto. City Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14 Informant (Address) 2101 Ballow ave

15 NOV 7 - 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 4th, 1922, to Nov 4th, 1922, that I last saw her alive on Nov 4th, 1922, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion a few hours after eating a hearty dinner

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Vomiting undigested food

(Signed) John D. Cunningham, M. D.

, 19 (Address) 1826 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

London Park Cem. Nov. 7 1922

UNDERTAKER Wm. C. Black 927 N. Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *613 China* ST. *22* WARD)

2-FULL NAME

Seroy Gross

(a) RESIDENCE NO.

613 China

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

1 yrs. *7* mos. *27* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Col.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar, 8, 1921

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

*1**7**27*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

William Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Maryland

12 MAIDEN NAME OF MOTHER

Bessie Otho

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Maryland

14

Informant

(Address)

*Bessie Gross**613 China St*

15

*NOV 7 - 1922**ROBERT R. KRAUTER,**Burial Permit Clerk.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov, 4, 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 12, 1922* to *Nov, 4, 1922*. that I last saw him alive on *Nov, 4, 1922*, and that death occurred, on the date stated above, at *11 05 P. m.* The CAUSE OF DEATH* was as follows:*acute Broncho Pneumonia*(duration) yrs. mos. *22* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *no*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *David Traubner* M. D.*11/6, 1922* (Address) *122 W. See St*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Agnes

20 UNDERTAKER

*Harold Epton**Oct 7 1922*ADDRESS *916**Per as*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. — 1-10-21—M&T—1500 Bks.

9068984 HEALTH DEPARTMENT—CITY OF BALTIMORE 9068984

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE, NO. 1609 Bolton ST. 14 WARD)
2-FULL NAME Philip M. Tabb Jr.
(a) RESIDENCE NO. 1609 Bolton St. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS
3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) widowed
5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hester Ferguson Tabb
6 DATE OF BIRTH (month, day, and year) 1846
7 AGE Years 75 Months Days If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired 045
(b) General nature of industry, business, or establishment in which employed (or employer) Merchant
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va
10 NAME OF FATHER Don't Know
11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know
12 MAIDEN NAME OF MOTHER Don't Know
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant (Address) Armstrong Thomas 1605 Bolton St.

15 NOV 7 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) Nov 4 1922
17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1922, to Nov 4, 1922, that I last saw him alive on Nov 4, 1922, and that death occurred, on the date stated above, at 8:30 P. m.
The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
Myocarditis
(duration) Many mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? none
(Signed) Chas W. Larnet, M. D.
, 19 (Address) 1327 Park Ave
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL
Green Mount Nov 8 1922

20 UNDERTAKER ADDRESS
John Ottitchell 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Fka.

268985

HEALTH DEPARTMENT—CITY OF BALTIMORE

268985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 732 N Carrollton Ave. 16 WARD)

2-FULL NAME

Emory F. Lane

(a) RESIDENCE NO. 732 N Carrollton Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Susie A. Lane

6 DATE OF BIRTH (month, day, and year) Nov 15 - 1839

7 AGE

83

Years

Months

20

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York (State or country)

10 NAME OF FATHER Daniel Lane

11 BIRTHPLACE OF FATHER (city or town) N.Y. (State or country)

12 MAIDEN NAME OF MOTHER Amelia Coldgrove

13 BIRTHPLACE OF MOTHER (city or town) N.Y. (State or country)

14 Informant Susie A. Lane (Address) 732 N Carrollton Ave.

15 NOV 7 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 22, 1922, to Nov 5, 1922.

that I last saw him alive on Nov. 5, 1922.

and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY Arteriosclerosis (Secondary)

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs and symptoms (Signed) Charles G. G. M. D.

Nov 6, 1922 (Address) 114 W. Landon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-MOVAL DATE OF BURIAL

London Park Nov 8 1922

20 UNDERTAKER ADDRESS

John Outtitchell 120 W. Landon St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—K. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE No. 3842 Reisterstown Road ST. 15 WARD

2-FULL NAME

Sarah Elizabeth Mathews

(a) RESIDENCE

No. 3842 Reisterstown Road

ST.

WARD.

(If nonresident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 16 1868

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

7

21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Trained Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ewing New Jersey

10 NAME OF FATHER

William Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Barnaget New Jersey

12 MAIDEN NAME OF MOTHER

Rebecca Firman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ewingville New Jersey

14

Informant (Address)

Mrs. William Shulley 3842 Reisterstown Road

15

NOV 7-1922

ROBERT N. KRAUTER, Registrar Burial Permits Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 7 1922

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1922, to November 7, 1922.

that I last saw him alive on November 3, 1922, and that death occurred, on the date stated above, at 12-30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds. Anemia

18 Where was disease contracted if not at place of death?

U. S. A.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathological

(Signed) William H. Hill M. D.

Nov 7 1922 Address 1418 Eastern Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Ewing New Jersey

Nov 7 1922

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 703 Portlend

2-FULL NAME Motieus Zvirblis

(a) RESIDENCE. No. 703 Portlend
(Usual place of abode)

Length of residence in city or town where death occurred

yrs

mos.

ds.

How long in U. S., if of foreign birth?

25

yrs

mos.

ds.

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

ST. 71 WARD

ST. WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed,
or Divorced (write the word)
Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE 56 Years Months Days If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Tailor

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

Nok.

9 BIRTHPLACE (city or town)
(State or country)

Lithuania

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Lithuania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Lithuania

14

Informant V. Cepitis
(Address) 814 W Lombard Street

15

NOV 7 - 1922 ROBERT R. KRAUTER,
Bureau Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1922

17

I HEREBY CERTIFY, That I attended deceased from
October 22, 1922, to Nov. 5, 1922

that I last saw him alive on Nov. 5, 1922,

and that death occurred, on the date stated above, at 10:00 m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

CONTRIBUTORY (duration) yrs. 2 mos. 2 ds.
Pulmonary tuberculosis
(Secondary) (duration) yrs. 6 mos. 2 ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Brown, M. D.

11-6, 1922 (Address) 615 W. 13th St.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Loudon Park

Nov. 7th 1922

20 UNDERTAKER

ADDRESS

John Grebliauckas J. G. 425 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—PHYSICIANS should state
cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION
should be stated EXACTLY. See instructions on back of certificates.

state should be stated EXACTLY. PHYSICIANS should state of OCCUPATION. Exact statement of cause of death in plain terms, so that it may be properly classified. See instructions on back of certificates. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *37* WARD)

2-FULL NAME

Baby Backover ST. *37* WARD.

(a) RESIDENCE. NO.

(Usual place of abode) *744 McCabe St* ST. *37* WARD. (If nonresident give city or town and State)

Length of residence in city or town where death occurred

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 4, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *1* *45* *9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*

10 NAME OF FATHER *Harry E. Backover*

11 BIRTHPLACE OF FATHER (city or town) *Ellwood* (State or country) *Indiana*

12 MAIDEN NAME OF MOTHER *Irene Shook*

13 BIRTHPLACE OF MOTHER (city or town) *Ellwood* (State or country) *Indiana*

14 Informant (Address)

Harry E. Backover
744 McCabe St

15

NOV 7 - 1922

ROBERT R. KRAUTER
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 5, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Nov 4, 1922*, to *Nov 5, 1922*, that I last saw him alive on *Nov 5, 1922*, and that death occurred, on the date stated above, at *11:55 P. m.*

The CAUSE OF DEATH* was as follows:

Prematurity
(36 wks gestus)

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. Norwood Wilson, M. D.
University Hospital

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Loudon Park

20 UNDERTAKER

John F. Denny

DATE OF BURIAL

Nov 7 1922

ADDRESS

715 Light St

D68489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68989

CERTIFICATE OF DEATH.

101-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1212 N. Caroline St. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Isaac Noritch

(a) RESIDENCE NO. 1212 N. Caroline St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 80 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Noritch

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 32 — —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vest Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Ora Noritch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Beanie Dofkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E. 1st St.

15 NOV 7-1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7 1922

17 I HEREBY CERTIFY, That I attended deceased from November 1st 1922, to Nov 7, 1922 that I last saw him alive on Nov 7, 1922 and that death occurred, on the date stated above, at 3 am. The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pharyngeal (Signed) A. G. Hornstein M. D.

11/7, 1922 (Address) 733 Argus St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Nehru Roseale

DATE OF BURIAL

11/7 1922

20 UNDERTAKER

Jack Lewis 1439 E. 1st St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. JOHNS HOPKINS HOSPITAL ST., WARD)

2-FULL NAME

William Cook

(a) RESIDENCE NO.

641 N. Canton St

(Usual place of abode)

Length of residence in city or town where death occurred

life

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female Black Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofChester Cook

6 DATE OF BIRTH (month, day, and year)

Dec-29-?

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.30

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Ind

10 NAME OF FATHER

Geo E Wheeler

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ind

12 MAIDEN NAME OF MOTHER

Mary Washington

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ind

14

Informant
(Address)JOHNS HOPKINS HOSPITAL

15

Filed

NOV 7-1922ROBERT R. KRAUTER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 3- 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 31- 1922, to Nov 3- 1922

that I last saw her alive on

Nov 3- 1922

and that death occurred, on the date stated above, at

3:30 p m.

The CAUSE OF DEATH* was as follows:

Heart disease (myocardial failure)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. 8 mos. ds.

18 Where was disease contracted

if not at place of death? UnknownDid an operation precede death? no Date ofWas there an autopsy? YesWhat test confirmed diagnosis? Autopsy

(Signed)

Chas. R. B. B. B.

M. D.

Address

Johns HopkinsThorpe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Claburn CemNov 7-22

20 UNDERTAKER

ADDRESS

Samuel H. B. B.378

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 Myrtle Av ST., 4 WARD)2-FULL NAME John Boone(a) RESIDENCE NO. 304 Myrtle Av ST., 4 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown6 DATE OF BIRTH (month, day, and year) Feb 18207 AGE Years 98 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bilger Co (State or country) Ind10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)14 Informant (Address) Dr. H. H. Hays15 Filed Nov 7-1922 ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 3 192217 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922, to Nov 3, 1922, that I last saw him alive on Nov 2, 1922, and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency
+ Arterio SclerosisCONTRIBUTORY (Secondary) Exhaustion (duration) 7 yrs. mos. ds.(duration) 4 yrs. mos. ds.18 Where was disease contracted if not at place of death? ?Did an operation precede death? No Date of ?Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Hughes, M. D., 19 (Address) 637 Mosher St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL National Cem DATE OF BURIAL Nov 7 192220 UNDERTAKER James P. Dushy ADDRESS 1138

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

PARENTS

14 Informant (Address)

15

NOV 7-1922

ROBERT B. KRANTZ Registrar

Bureau Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY That I attended deceased from Oct. 30, 1922, to Nov. 7, 1922.

that I last saw him alive on Nov. 7, 1922.

and that death occurred, on the date stated above, at 8:05 A. M.

The CAUSE OF DEATH* was as follows:

1. Chronic cholecystitis
 2. Cholelithiasis
 3. Chronic nephritis
 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH CAPITALS. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

068993

HEALTH DEPARTMENT—CITY OF BALTIMORE

068993

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2218 Henneman Ave. St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Mary Karmner
(Residence in Baltimore: No. 2218 Henneman Ave. St.; yrs.,..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Single, Married, Widowed, or Divorced, (Write the word.)
Female White

6-DATE OF BIRTH, Sept 30, 1878
(Month) (Day) (Year)

7-AGE, 44 yrs., 1 mos., 7 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, At home
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Balto md

10-NAME OF FATHER, Frederick Kengel

11-BIRTHPLACE OF FATHER, (State or Country), Balto md

12-MAIDEN NAME OF MOTHER, Mary Blanche

13-BIRTHPLACE OF MOTHER, (State or Country), Balto md

14-IF THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Kengel (Son)
(Address) 918 N. E. Ave.

NOV 7-1922
Filed 1922

ROBERT R. KRAUTER,
Bureau Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 6, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Asphyxia

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
Tuberculosis

(Signed) J. S. H. Patten M. D.
(Coroner)

11-6 1922 (Address) 508 E. North Ave.

*State the Disease causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Balto Cum 11/8/1922

20-UNDERTAKER, ADDRESS 2016

Philip Herwig Orleans St.

D68994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D68994

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1931 Reservoir St. ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Ruth Williams

(a) RESIDENCE NO.

1931 Reservoir St. ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofChild

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

12 Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

School Girl

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Baltimore

10 NAME OF FATHER

Raymond Cole11 BIRTHPLACE OF FATHER (city or town)
(State or country)MD

12 MAIDEN NAME OF MOTHER

Ladie Williams13 BIRTHPLACE OF MOTHER (city or town)
(State or country)MD

14

Informant
(Address)Mother, Ladie Williams
1931 Reservoir St.

15

NOV 7 - 1922ROBERT R. KRAUTER,Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 4 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 25, 1922, toNov. 3, 1922.

that I last saw her alive on

Nov. 3, 1922.

and that death occurred, on the date stated above, at

1:40 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)Cold Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

unknown

Did an operation precede death?

no Date of no

Was there an autopsy?

no

What test confirmed diagnosis?

Physical Exam

(Signed)

Ed. Hall

M. D.

, 19

(Address)

424 E 23 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Laurel CemeteryNovember 7, 1922

20 UNDERTAKER

Mrs Robert A. ElliottADDRESS 1725

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Hks.

68995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 68995

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

625 N. Central Ave

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Harry Joseph Barber

(a) RESIDENCE. NO.

625 N. Central Ave

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

34 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Mr.

6 DATE OF BIRTH (month, day, and year)

1888

7 AGE

34

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

George Barber

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14

Informant (Address)

Emma A. Barber 625 N. Central Ave

15

NOV 7 - 1822

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 5 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 26 1922, to Nov 5 1922

that I last saw him alive on Nov 5 1922

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Myocardia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Regular

(Signed)

Nov 7 1922 1313 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mount Auburn Cem

Nov 8 1922

20 UNDERTAKER

ADDRESS

Mrs. Uhas. B. Jones

1725 Ashland Ave

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Mitral Regurgitation
No other history.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D68996

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *Univ Hospital* ST. *4* WARD)

2-FULL NAME

Laura V Rowles

(a) RESIDENCE. NO.

Elkridge, Md

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

24 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown. 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Elkridge Maryland

10 NAME OF FATHER

Charles Rowles

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Stamow Md.

12 MAIDEN NAME OF MOTHER

Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

Hospital Records

15

NOV 7 - 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 5th 1922*

17 I HEREBY CERTIFY, That I attended deceased from

*October 17, 1922, to Nov. 5, 1922*that I last saw her alive on *Nov. 5, 1922*and that death occurred, on the date stated above, at *8:00 P. m.*

The CAUSE OF DEATH* was as follows:

Cholecystitis, Cholelithiasis and Cholangitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chol (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

*Home*Did an operation precede death? *NO* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *History Lab. & Clinical findings*

(Signed)

E. G. Haller M. D.

(Address)

Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Augustine Ave. Elkridge Md**Nov 8th 1922*

20 UNDERTAKER

ADDRESS

*John J. Conway & Son**901 Haller St.*

268997

HEALTH DEPARTMENT—CITY OF BALTIMORE

268997

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1410 N. Mount ST. 12 WARD)

2-FULL NAME John Wesley Alton

(a) RESIDENCE NO. 1410 N. Mount ST. 12 WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucas 5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed, or divorced HUSBAND of Annie Alton (or) WIFE

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 60 Months — Days — If LESS than 1 day, hrs. — or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day labour

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Annapolis County Md.

10 NAME OF FATHER John Alton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis County Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis County Md.

14 Informant Joshua Alton (Address) 11724 N. Mount St.

15 NOV 7-1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1922, to Nov. 4, 1922, that I last saw him alive on Nov. 4, 1922, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 4, 1922

Was there an autopsy? Yes

What test confirmed diagnosis? Histology

(Signed) John S. Quinn, M. D.

(Address) 1507 N. Fulton Cor.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Friendsburg, Pa. Co. 7 ad. Nov. 8 1922

20 UNDERTAKER ADDRESS James A. Quinn

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

068998

HEALTH DEPARTMENT—CITY OF BALTIMORE

068998

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3006 Kate Avenue

ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor von Nagel

(a) RESIDENCE No. 3006 Kate Avenue

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. -- mos. -- ds.

How long in U. S., if of foreign birth? 25 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick William von Nagel

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1854

7 AGE Years 68 Months 0 Days 13 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bristol (State or country) England

10 NAME OF FATHER John Sullivan

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Catherine O'Connell

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs. J. Leo Flanigan (Address) 3006 Kate Avenue

15 ROBERT R. KRAUTER, Burial Permit Clerk

NOV 7-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5-1922

17 I HEREBY CERTIFY, that I attended deceased from Nov 3, 1922, to Nov 5, 1922.

that I last saw him alive on Nov. 5, 1922.

and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Pneumonia 3 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted 3006 Kate Ave if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? (Signed) Robert F. Hardsch, M. D.

11, 19 (Address) Main Hayward

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL 11/8 1922

20 UNDERTAKER Henry W. Hears & Son 805 N. Calvert ADDRESS

MARGIN RESERVED FOR
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

Rusinek ✓
1-004 *D 68999*
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *614 S Chapel* ST. *V* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Rozalia Rusinek*

(a) RESIDENCE NO. *614 S Chapel* ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sep 3 1912*

7 AGE Years Months Days If LESS than 1 day, hrs or min.
10 2 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *School*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country)

10 NAME OF FATHER *Symon Rusinek*

11 BIRTHPLACE OF FATHER (city or town) *Poland* (State or country)

12 MAIDEN NAME OF MOTHER *Felicia Buczek*

13 BIRTHPLACE OF MOTHER (city or town) *Poland* (State or country)

14 Informant *Mrs Felicia Rusinek* (Address) *614 S Chapel*

15 *NOV 7 - 1922* *ROBERT R. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 5 1922*

17 I HEREBY CERTIFY, That I attended deceased from

Oct 28 1922, to *Nov 5 1922*

that I last saw him alive on *Nov 5 1922*

and that death occurred, on the date stated above, at *1143 Pm.*

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. J. Weber* M. D.

(Address) *140 B...*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Rosary

Nov 8 1922

20 UNDERTAKER

ADDRESS

John M. Weber

1803 Bank St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2529 Madison Ave. WARD 31)

2. FULL NAME

(a) RESIDENCE NO. 2529 Madison Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Seif6 DATE OF BIRTH (month, day, and year) Dec. 17 18587 AGE Years 63 Months 10 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) New York (State or country)10 NAME OF FATHER Simon Seif11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14

Informant (Address) Mr. Irving Seif
2529 Madison Ave.

15

NOV 7 - 1922

ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/6/192217 I HEREBY CERTIFY, That I attended deceased from Sept 4 1922, to Nov 6 1922, that I last saw him alive on Nov 6 1922, and that death occurred, on the date stated above, at 1:20 A. M.

The CAUSE OF DEATH* was as follows:

Chronic MyocarditisCONTRIBUTORY probably (duration) 3 yrs. mos. ds. Chr. Nephritis (Secondary) (duration) 3 yrs. mos. ds.18 Where was disease contracted if not at place of death? don't knowDid an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) Martin F. Sloan M. D.11.7.1922 (Address) Professional Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Chet Shalom Cem.

20 UNDERTAKER

David Sondheim

DATE OF BURIAL

11/8/1922

ADDRESS

118 W. Mt Royal Ave

MARGIN RESERVE—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "*Laborer*," "*Foreman*," "*Manager*," "*Dealer*," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Pulmonary Tuberculosis.

MARGIN RESERVED FOR
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

269001 HEALTH DEPARTMENT—CITY OF BALTIMORE 269001

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 E. North Ave ST. 12 WARD)

2. FULL NAME John Thomas Brown

(a) RESIDENCE NO. 213 E. North Ave. ST. WARD

(Usual place of abode) Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret E. Brown.

6 DATE OF BIRTH (month, day, and year) September 8th, 1872

7 AGE Years 50 Months 1 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore Md. (State or country)

10 NAME OF FATHER Thomas Brown

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Ann Rebecca Johnson

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. Md. (State or country)

14 Informant Mrs Margaret E. Brown (Address) 213 E. North Ave.

15 NOV 7-1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5th, 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1922 to Nov. 5, 1922 that I last saw him alive on Nov. 5, 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

CONTRIBUTORY (duration) yrs. 2 mos. ds. Chronic Interstitial Nephritis (Secondary) (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Partial What test confirmed diagnosis? Laboratory (Signed) Herbert C. Blake, M. D.

19 (Address) 1014 W 12 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park Cemetery

20 UNDERTAKER

Edmund W. Gore

DATE OF BURIAL

Nov 8th 1922

ADDRESS

1014 W 12 St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

2 yrs. 6 mos. ?

ds.

How long in U. S., if of foreign birth? 81 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced, name of HUSBAND of (or) WIFE of

Samuel L. Lacey

6 DATE OF BIRTH (month, day, and year)

About 1841

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

81

0

0

0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Springfield Township

Md.

10 NAME OF FATHER

Thomas Stiles

11 BIRTHPLACE OF FATHER (city or town) (State or country)

York Co

Pa.

12 MAIDEN NAME OF MOTHER

Cath. Strayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

York Co

Pa.

14

Informant (Address)

Records of Mt Hope

Mt Hope Retreat

15

Filed

19

NOV 7-1922

ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6th 1922

17

I HEREBY CERTIFY, That I attended deceased from Sept 21st, 1922, to Nov 6th, 1922,that I last saw him alive on Nov 5th, 1922,

and that death occurred, on the date stated above, at 10.45 A. M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis -

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 7 ds.

Dysentery Acute

(duration) 2 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? York Co Pa

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed)

Nov 6, 1922 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Shrewsbury - Pa.

Nov 8- 1922

20 UNDERTAKER

ADDRESS

STEWART & MOWEN COMPANY

108 W. NORTH AVE

WILLIAM F. WOODEN, Successor

MARGIN RESERVED FOR PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MARGIN RESERVED FOR DIVISION OF HEALTH
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

069003

HEALTH DEPARTMENT—CITY OF BALTIMORE

069003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 1126 Wm.berry ST., 18 WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs.

mos.

ds.

How long in U. S., If of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Edw. Murphy

6 DATE OF BIRTH (month, day, and year)

Oct 2 1877

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

45

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

Vermont

10 NAME OF FATHER

Thomas Murphy

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Hannah O'Connell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Ireland

14

Informant

(Address)

John Murphy
1126 Wm.berry

15

NOV 7-1922

ROBERT R. KRAUTER,

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 13 1921 to Nov 5 1922

that I last saw her alive on Nov 4 1922

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

W. A. O'Neill, M. D.

(Address) 108 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Calhoun

20 UNDERTAKER

H. C. Brannings, Jr.

DATE OF BURIAL

Nov 8 1922

ADDRESS 517 N.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

69004 HEALTH DEPARTMENT—CITY OF BALTIMORE 69004

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1217 N. Ruedell 23 WARD)

REGISTERED NO. 69004
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Codd
(a) RESIDENCE NO. 1217 N. Ruedell ST. WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/6/1852

7 AGE Years 70 Months 9 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Joseph Phelan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Roche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Jane Manley (Address) 1217 N. Ruedell St.

15 Filed 1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 20 1922, to Nov 5 1922, that I last saw alive on Nov 4 1922, and that death occurred, on the date stated above, at 109 m.

The CAUSE OF DEATH* was as follows:

Inferiorities of age
Duration 6 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Asthma (duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) H. H. Thompson, M. D. 19 (Address) 1340 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Jno J. Fahy & Sons 1318 Light

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

69005

HEALTH DEPARTMENT—CITY OF BALTIMORE

69005

CERTIFICATE OF DEATH.

105

REGISTERED NO. 69005
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 23 Jefferson ST., 6 WARD)

2-FULL NAME

Philip Withner

(a) RESIDENCE NO.

24 23 Jefferson ST.,

WARD

(If non-resident, give city or town and State)

(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds.

How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE white
5 Single, Married, Widowed, or Divorced, (write the word) Married
5a If married, widowed, or divorced, HUSBAND of Ida M. Withner
WIFE of

6 DATE OF BIRTH (month, day, and year) March 14 1878
7 AGE 44 Years 8 Months 5 Days
If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work commission merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Christian Withner

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Matthae

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

Ida M. Withner
24 23 Jefferson ST.

15

Filed

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 2, 1922 to Nov 6, 1922
that I last saw him alive on Nov 6, 1922, at 4:30 p.m.
and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

CONTRIBUTORY (Secondary) Cardiac Asthma
(duration) 6 yrs. mos. ds.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?
(Signed) Edward Leach, M.D.
(Address) 4137 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery
Mrs C. Miller

DATE OF BURIAL

Nov 8 1922
ADDRESS 2334 Jefferson

NOV 8 - 1922

MARGIN RESERVED FOR BINDING. Every item of information should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION. N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. *2816 Jefferson* ST., *7* WARD)

2-FULL NAME

(a) RESIDENCE NO. *2816 Jefferson* ST., *7* WARD

(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

George H. Gower

6 DATE OF BIRTH (month, day, and year)

June 17 1893

7 AGE

29 Years *11* Months *5* Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Thomson Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Puckett Atwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Maryland

14 Informant (Address)

Chas E Gower
2816 Jefferson St

15

NOV 8 - 1922

ROBERT R. KRAUTER,
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 3 1922

17 I HEREBY CERTIFY, That I attended deceased from

Sept 3 1922 to *Nov 6 1922*

that I last saw him alive on *11 5 1922*

and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH* was as follows

Gastritis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

old age

18 Where was disease contracted if not at place of death?

yes

Did an operation precede death? Date of

no

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed) *A. A. Bear* M. D.

117 1922 (Address) *2600 E. Baltimore St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

Friendship Cem, A. A. B. Nov 8 1922

20 UNDERTAKER

Mrs C. Miller

2334 Jefferson St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

69007

HEALTH DEPARTMENT—CITY OF BALTIMORE

69007

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 25 E Haywood ST., 27 WARD)

2-FULL NAME

(a) RESIDENCE No. 25 E Haywood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise M. Cook

6 DATE OF BIRTH (month, day, and year) Dec 12 1850

7 AGE Years 72 Months 10 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country)

10 NAME OF FATHER David H. Cook

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER David H. Cook

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Margaret H. Cook (Address) 282 Haywood

15

Filed NOV 8-1922 REGISTRAR ROBERT S. KRAUTH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1922

17 I HEREBY CERTIFY, That I attended deceased from July 1922, to Nov 1 1922,

that I last saw him alive on Nov 1 1922,

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter H. Cook, M. D.

117. 1922 (Address) 340 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Mt. Carmel Nov 9 1922

20 UNDERTAKER ADDRESS

H. M. Cook N. & A. M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed,
or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

64 Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant

(Address)

15

NOV 8-1922

ROBERT H. KRAUTH
Registrar
Burial Permit Clerk

ST.:

WARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

ST.:

WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from
Apr. 20, 1922, to Nov. 7, 1922,

that I last saw him alive on Nov. 6, 1922,

and that death occurred, on the date stated above, at 4:14 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) about 1 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exam. Urine, 24 hours

(Signed) Chas. T. McCarthey, M. D.

19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

Woodland Cemetery 11/9/22
Chas. Levee 607 N. Antioch

Exact statement of cause of death should be carefully supplied. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

69009 HEALTH DEPARTMENT—CITY OF BALTIMORE 69009 46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17 E. White Ave. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Lavinia Taylor.*

(a) RESIDENCE. No. 17 E. White Ave. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced (or) WIFE of *HUSBAND of Edgar M. Taylor*

6 DATE OF BIRTH (month, day, and year) *Dec 18 1864*

7 AGE Years Months Days If LESS than 1 day, hrs. or min. *57 10 11*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer) *Domestic*

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)

10 NAME OF FATHER *Matthew W. Smith*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Margaretta Brooks*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *Md*

14 Informant *Mrs. Margaretta Smith* (Address) *17 E. White Ave.*

15 Filed *NOV 8 - 1922* 19 *ROBERT H. KRAUTER* Registrar *Bureau Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 7 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Nov. 5 1919*, 19 to *Nov. 7*, 19 *22*.

that I last saw her alive on *November 6*, 19 *22*.

and that death occurred, on the date stated above, at *10 a* m.

The CAUSE OF DEATH* was as follows:

*Carcinoma of Cervix, metastatic
Liver & stomach*

(duration) *3* yrs. *3* mos. — ds.

CONTRIBUTORY *Metastasis to bladder* (Secondary)

(duration) *2* yrs. — mos. — ds.

18 Where was disease contracted *1109 N. Gilman St* if not at place of death?

Did an operation precede death? *none* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Clinical examination*

(Signed) *Charles E. Clark*, M. D.

1922 (Address) *1306 N. Gilman St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Baltimore

11/9 2

20 UNDERTAKER

ADDRESS

Wm Cor 16 *502 E Nnd*

D 69011 HEALTH DEPARTMENT—CITY OF BALTIMORE D 69011

CERTIFICATE OF DEATH.

99-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19th Luzerne ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James W. Lewis

(a) RESIDENCE NO.

19th Luzerne ST., 6 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of

(or WIFE of)

Bertha D. Lewis

6 DATE OF BIRTH (month, day, and year)

May 12-1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

58

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Chief Constable

(b) General nature of industry, business, or establishment in which employed (or employer)

Balto. City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. City

10 NAME OF FATHER

Christopher Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. City

12 MAIDEN NAME OF MOTHER

Rosa Gamble

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. City

14

Informant (Address)

Bertha D. Lewis 19th Luzerne St.

15

Filed

NOV 8 - 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 5 1922

17 I HEREBY CERTIFY, That I attended deceased from

Nov 5 1922 to Nov 5 1922

that I last saw him alive on Nov 5 1922

and that death occurred, on the date stated above, at 2 PM.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration)

20 minutes

CONTRIBUTORY (Secondary)

(duration)

6 mos.

18 Where was disease contracted

if not at place of death?

don't know

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

Chemical

(Signed)

Wm. J. Gossley, M. D.

, 19

(Address)

2258 E. Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Volhane Cemetery

11/8/1922

20 UNDERTAKER

J. G. Moran

ADDRESS

3000 E. Balt.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

69012

HEALTH DEPARTMENT—CITY OF BALTIMORE

69012

CERTIFICATE OF DEATH.

188-003

1-PLACE OF DEATH

City of BALTIMORE: (No.

Mercy Hospital 17
Joseph Trombieri
603 Penna. av.

Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. *Married*
(Write the word.)

6-DATE OF BIRTH

(Month) (Day) (Year)

7-AGE

40

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).Lunch room
keeper 1869-BIRTHPLACE.
(State or Country).

Italy

10-NAME OF FATHER.

A. J. Trombieri

11-BIRTHPLACE OF FATHER.
(State or Country).

Italy

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Joseph Klaus

(Address)

603 Penna. av.

15-NOV 8-1922

ROBERT K. KRAUTER,

Filed

1922

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

(Month) (Day) (Year)

Nov 5-1922

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fract. skull - Driving
an auto when it suddenly
turned over.
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

New Cathedral

11/8 1922

20-UNDERTAKER.

ADDRESS

James H. Toulson

1244 1/2 Green St.

N. B.—WRITE PLAINLY, WITH CARE. Exact statement of OCCASION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

6-9-19—H. P. Co.—1000 Bks.

D69013 HEALTH DEPARTMENT—CITY OF BALTIMORE **D69013**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 902 Harford Ave ST. 10 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa C. Evans.

(a) RESIDENCE. No. 902 Harford Ave ST. WARD. (If nonresident give city or town and State)

(Usual place of abode) about Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry R. Evans

6 DATE OF BIRTH (month, day, and year) April 23/86

7 AGE Years 61 Months 5 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Domestic (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York, Pa.

10 NAME OF FATHER George C. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry R. Evans (Address) 902 Harford Ave

15 Filed NOV 8 - 1922 19 ROBERT R. KRAUTER Registrar

16 DATE OF DEATH (month, day, and year) Nov. 5 - 1922

17 I HEREBY CERTIFY, That I attended deceased from OCT 28 1922, 19 to NOV 4 - 1922, 19 that I last saw her alive on NOV 4 - 1922, 19 and that death occurred, on the date stated above, at 1130a m.

The CAUSE OF DEATH* was as follows: acute Dilatation of heart after Myocarditis (duration) X yrs. X mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 5 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? Did an operation precede death? No Date of Was there an autopsy? No What test confirmed diagnosis Fehling's test for sugar (Signed) J. H. Decker M. D. Address 928 North St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Nov. 8 1922

20 UNDERTAKER Charles W. Conklin ADDRESS 924 E. Ave. St.

D69014

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69014

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5003 O. Donnell ST., 26 WARD)2-FULL NAME Margaret Schorr(a) RESIDENCE NO. 5003 O. Donnell ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Schorr6 DATE OF BIRTH (month, day, and year) April 30, 18557 AGE Years Months Days If LESS than 1 day, hrs or min. 67

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)10 NAME OF FATHER John Jaerberlein11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Margaret Shick13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)14 Informant Christian Schorr (Address) 5003 O. Donnell St.15 NOV 8 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 4 19 2217 I HEREBY CERTIFY, That I attended deceased from Nov 1, 19 22, to Nov 4, 19 22.that I last saw him alive on Nov 3, 19 22.and that death occurred, on the date stated above, at 7:40 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY Acute Myocarditis (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Observed(Signed) Harold J. Zittel M.D.Address 215 S. Highland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Chm.

DATE OF BURIAL

Nov. 8 19 22

20 UNDERTAKER

Lilly and Zittel

ADDRESS

403 S. Weyer

N. B.—WRITE PLAINLY, WITH ONE NAME ONLY. AGE should be carefully supplied. AGE should be stated exactly. Exact statement of OCCASION should be in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69015 HEALTH DEPARTMENT—CITY OF BALTIMORE D69015	
CERTIFICATE OF DEATH.	
1-PLACE OF DEATH	
City of BALTIMORE: (No. 922 M ^c . Culloh St. 11 Ward)	
2-FULL NAME John W. Carter	
(Residence in Baltimore: No. 922 M ^c . Culloh St. 11 yrs. 3 mos. ds.)	
Registered No. C.....	
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
PERSONAL AND STATISTICAL PARTICULARS.	
3-SEX, male	4-COLOR OR RACE, colored
5-Single, Married, Widowed, or Divorced, (Write the word.) single	
6-DATE OF BIRTH, July 30, 1921	
7-AGE, 1 yrs. 3 mos. 7 ds. If LESS than 1 day, ... hrs. or ... min.?	
8-OCCUPATION:	
(a) Trade, profession, or particular kind of work, none	
(b) General nature of industry, business, or establishment in which employed (or employer),	
9-BIRTHPLACE, (State or Country), Balto. Md.	
PARENTS.	10-NAME OF FATHER, Will Carter
	11-BIRTHPLACE OF FATHER, (State or Country), Md.
	12-MAIDEN NAME OF MOTHER, Callie Crowley
	13-BIRTHPLACE OF MOTHER, Va.
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.	
(Informant) Mrs. W. Carter	
(Address) 922 M ^c . Culloh St.	
15-Filed NOV 8-1922	ROBERT R. KRAUTER, Burial Permit Clerk.
CORONER'S CERTIFICATE OF DEATH.	
16-DATE OF DEATH, Nov. 6, 1922	
17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.	
The CAUSE OF DEATH* was as follows:	
Dys - colitis	
(Duration) ... yrs. ... mos. ... ds. 2	
CONTRIBUTORY (Secondary) no history	
(Signed) J. T. Hennessy, M. D. (Coroner)	
Nov. 7, 1922 (Address) 280 E. Lombard St.	
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).	
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.	
Where was disease contracted, if not at place of death?	
Former or usual residence	
19-PLACE OF BURIAL OR REMOVAL, Laurel St.	DATE OF BURIAL, Nov 8, 1922
20-UNDERTAKER, J. W. Brown & Son	ADDRESS, 1630 Montgo St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *Morrow Hospital* ST. *16* WARD)2. FULL NAME *Richard Liberty, alias, Frank Sawyer*(a) RESIDENCE NO. *464 Ferry St., Albany, N.Y.* WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *unknown* mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *—*6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *5-1*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Able Seaman*(b) General nature of industry, business, or establishment in which employed (or employer) *Merchant Marine*(c) Name of employer *—*9 BIRTHPLACE (city or town) *Unknown* (State or country)10 NAME OF FATHER *Unknown*11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country)12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)14 Informant *Patent's History* (Address)15 *NOV 8 - 1922* *ROBERT R. KRAUTER,* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *11/5/1922*17 I HEREBY CERTIFY, That I attended deceased from *9/5/1922* to *11/5/1922*, that I last saw him alive on *11/5/1922*and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

*Valvular Disease, Chronic Cardiac*CONTRIBUTORY (Secondary) *Chronic Nephritis* (duration) ? yrs. mos. ds.

(duration) ? yrs. mos. ds.

18 Where was disease contracted *Unknown* if not at place of death?Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*What test confirmed diagnosis? *Physical Examination* (Signed) *P.E. Schools*, M. D.*11/5/1922* (Address) *Morrow Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*New Cathedral**11/8/1922*

20 UNDERTAKER

ADDRESS *1127**Robinson & Bros E Balto St*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE PHYSICIAN SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. EXACT STATEMENT OF OCCUPATION SHOULD BE CAREFULLY SUPPLIED. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Johner
HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1551 Friendstury ST.: 15 WARD) 90

2-FULL NAME Edith Johner

(a) RESIDENCE. No. 1551 Friendstury ST.: _____ WARD. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. — mos. 35 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced
WIFE of Marcellus Johner

6 DATE OF BIRTH (month, day, and year) Sept. 29, 1903

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
19 — 35

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

10 NAME OF FATHER August C. Snyder

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Lietta Schasowitz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Lietta Snyder
(Address) 1551 Friendstury St.

15 Filed _____, 19 NOV 8 - 1922 RUBEN H. KRAUTER, Registrar
Burial Permit Clerk.

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6, 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1922 to Nov. 4, 1922
that I last saw him alive on Nov. 4, 1922
and that death occurred, on the date stated above, at 1:50 A. M.
The CAUSE OF DEATH* was as follows:
Myocardial degeneration
(duration) yrs. mos. 36 ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted _____
if not at place of death?

Did an operation precede death? _____ Date of _____

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) John D. Quinn M. D.
Nov. 6, 1922 Address 1501 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Violettsville Md DATE OF BURIAL 11/8/22

20 UNDERTAKER Geo. Weber & Son 2503 Edmond St ADDRESS _____

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Walbrook Ave., ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Tenna Schuchat(a) RESIDENCE No. 1827 Walbrook Ave., ST. 15 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofDavid Schuchat6 DATE OF BIRTH (month, day, and year) 18477 AGE Years 75 Months - Days - If LESS than 1 day, hrs. - or min. -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14

Informant
(Address)Jack Lewis
1439 E. Madison St.

15

NOV 6 - 1922 ROBERT H. CLARK
Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1922

17

I HEREBY CERTIFY, That I attended deceased from

1917 to Nov 7 1922.that I last saw her alive on Nov. 7 1922.and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus(duration) 15 yrs. mos. ds.CONTRIBUTORY
(Secondary)Acidosis
(duration) 7 yrs. mos. 4 ds.18 Where was disease contracted
if not at place of death? 2Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Blood & urine(Signed) Milton H. Cumins, M. D.11/1, 1922 (Address) 311 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Heavenly Friendship Ch.
20 UNDERTAKER11/9 1922Jack Lewis 1439 E. Madison St.

ADDRESS

TION is very important. See instructions on back of certificates.

D69019 HEALTH DEPARTMENT—CITY OF BALTIMORE D69019
90 D69019
CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE No. 222 Eulan Plac 13
2-FULL NAME Joseph Rosenfeld
(Residence in Baltimore: No. 2221 Eulan Plac
REGISTERED No. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.
3-SEX. Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single
6-DATE OF BIRTH, December 1st, 1950
7-AGE, 71 yrs., 11 mos., 5 ds.
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Salesman
(b) General nature of industry, business, or establishment in which employed (or employer)
9-BIRTHPLACE, (State or Country), Germany
PARENTS.
10-NAME OF FATHER, Moses Rosenfeld
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Henrietta Neufeld
13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)... Cal. Israel Rosenfeld
(Address)... 2221 Eulan Plac

15-
Filed, NOV 5 1952, 101, ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.
16-DATE OF DEATH, Nov. 6th, 1952
17-I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, or inquiry thereon and from the evidence obtained by autopsy or inquiry on the day stated above.
The CAUSE OF DEATH* was as follows:
Coronary disease
Heart
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Signed) J. H. ... M. D.
(Coroner)
191... Address 7632 Blay
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death... yrs. mos. ds. In the State... yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence.
19-PLACE OF BURIAL OR REMOVAL, Date of BURIAL, 11/8/52
20-UNDERTAKER, Jack Lewis 14399 Balt

ADDRESS _____

11/8 192

20 UNDERTAKER	ADDRESS
Jack Lewis	1439 5th St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

069021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

069021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 E. Fayette

ST. 5 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Aaronson

(a) RESIDENCE No. 1021 E. Fayette

ST. 19 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER Isaac Aaronson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Russia

12 MAIDEN NAME OF MOTHER Ahama Agott

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Russia

14

Informant (Address)

15

Filed

19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 6 19 22, to Nov 7 19 22

that I last saw her alive on Nov 7 19 22

and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Ac Cardiac dilata

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed)

11/7/22 (Address) 210 Reservoir

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Jack Lewis, 1439 E. Race

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 5, 1922, to Nov 7, 1922

that I last saw him alive on Nov 7, 1922

and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) John S. Murray Jr., M. D.

(Address) 1107 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Alvathen
HEALTH DEPARTMENT—CITY OF BALTIMORE

D 69023

44 D 69023

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Mayland General Hospital*
CITY OF BALTIMORE: (No. *13* ST. *13* WARD)
2-FULL NAME *John Conrad Alvathen*
3713 Forest Park Ave ST. *13* WARD *13*
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS
3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *married*
6a If married, widowed, or divorced HUSBAND of (or) WIFE of *Letitia Brown*
6 DATE OF BIRTH (month, day, and year) *May-21-1849*
7 AGE Years *73* Months *5* Days *16* If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *none*
(b) General nature of industry, business, or establishment in which employed (or employer) *out*
(c) Name of employer
9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*
10 NAME OF FATHER *Conrad Alvathen*
11 BIRTHPLACE OF FATHER (city or town) *Germany* (State or country)
12 MAIDEN NAME OF MOTHER *Julia Guelcher*
13 BIRTHPLACE OF MOTHER (city or town) *Germany* (State or country)

14 Informant *Mrs. Albert Barker* (Address) *3713 Forest Park Ave*

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) *Oct. 6 1922*
17 I HEREBY CERTIFY, That I attended deceased from *Oct. 13 1922* to *Nov 6 1922*, that I last saw him alive on *Nov 6 1922*, and that death occurred, on the date stated above, at *1.10 P. m.*
The CAUSE OF DEATH* was as follows:
Carcinoma of Prostate
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. *3 mos.*
18 Where was disease contracted if not at place of death? *at home*
Did an operation precede death? *no* Date of
Was there an autopsy? *yes*
What test confirmed diagnosis? *Autopsy*
(Signed) *James Hubert Alderson* M. D.
(Address) *Old General Hospital*
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Mt. Carmel Cemetery* DATE OF BURIAL *11/9/22*

20 UNDERTAKER *Milton H. Jones* ADDRESS *424 N. Broadway*

ROBERT R. KRAUTER Registrar
Burial Permit

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mary Hospital.* ST. *8* WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

NOV 8 - 1932

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from *Nov 6, 1922* to *Nov 6, 1922*, that I last saw her alive on *Nov 6, 1922*, and that death occurred, on the date stated above, at *11 A. M.*

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed)

, 19 (Address)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

269025
1-PLACE OF DEATH

129 269025
REGISTERED NO.

CITY OF BALTIMORE: (No. 1434 N. Bond ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Hugg

(a) RESIDENCE No. 1434 N. Bond ST., WARD

(Usual place of abode) Length of residence in city or town where death occurred 65 yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? 5 yrs. 11 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, Divorced, (write the word) Widow

5a If married, widowed, or divorced Husband of (or) WIFE of Mr. Hugg

6 DATE OF BIRTH (month, day, and year) Nov. 29 1856

7 AGE Years 65 Months 11 Days 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

10 NAME OF FATHER Mr. H. Elliott

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary E. Farrington

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Mrs. N. Barbour (Address) 1434 N. Bond St.

15 Date 8-1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 6 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 11 1922, to Nov 6 1922, that I last saw her alive on Nov 5 1922

and that death occurred, on the date stated above, at 8:50 a.m.

The CAUSE OF DEATH* was as follows:

Bright's Disease (duration) 6 mos. or more

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1434 N. Bond St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary Analysis (Signed) J. H. Smith, M. D.

19 (Address) 1107 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-DATE OF BURIAL Baltimore Cemetery November 8, 1922

20 UNDERTAKER Henry Speck Low 1301 E. Eager

ROBERT R. KRAUTER
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69026

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

N69026

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Plaza Apt., Park Ave & Wilson* ST.: *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Martha S. Townsend

(a) RESIDENCE. NO.

Plaza Apt.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *802* yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female white

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov. 29-1837*

7 AGE

Years

Months

Days

If LESS than 1 day, — hrs. or — min.

84

11

23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Penn.

10 NAME OF FATHER

Sam'l Townsend

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pa.

12 MAIDEN NAME OF MOTHER

Mary Sleeper

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant (Address)

Miss Bertha Janner Plaza Apt.

NOV 3-1922

H. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 6 1922*

17

I HEREBY CERTIFY, That I attended deceased from *Nov. 2 1922*, to *Nov. 6 1922*,

that I last saw him alive on *Nov. 6 1922*,

and that death occurred, on the date stated above, at *11³⁰ P. M.*

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. *5* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Physical signs*

(Signed) *Walter A. Robinson*, M. D.

. 19 (Address) *1307 N. Charles St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Grave Care

Nov. 9 1922

20 UNDERTAKER

ADDRESS

Chas E. Pauck 802 Madison

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 S. Bond ST.; 3 WARD)

2-FULL NAME

(Residence in Baltimore: No. 610 S. Bond St.; 40 yrs., 11 mos., 25 ds.)

58-001
REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Widow
(Write the word.)

6-DATE OF BIRTH, November 10, 1886
(Month) (Day) (Year)

7-AGE, 35 yrs., 11 mos., 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Housewife
(b) General nature of industry, business, or establishment in which employed (or employer), None

9-BIRTHPLACE, (State or Country), Poland

10-NAME OF FATHER, Martin Reida

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patricia Kwiatkowski

(Address) 610 S. Bond St.

15- Nov 8 - 1922 191 Ham

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 5, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 30, 1922, to November 5, 1922, that I saw h. e alive on November 5, 1922, and that death occurred, on the date stated above, at 11:30 p.m. The CAUSE OF DEATH* was as follows:

Coronary Thrombosis
(Duration) 2 yrs., 2 mos., 25 ds.

CONTRIBUTORY Arteriosclerosis
(Secondary)

(Duration) 4 yrs., 4 mos., 25 ds.

(Signed) H. J. ... M. D.
Nov 6, 1922 (Address) 722 S. Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ys. mos. ds. In the State ys. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary DATE OF BURIAL, Nov 9, 1922

UNDERTAKER William G. ... ADDRESS 1118 Eastern

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

15-69028 HEALTH DEPARTMENT—CITY OF BALTIMORE 15-69028
71-001
1-PLACE OF DEATH *Johns Hopkins Hospital*
City of BALTIMORE: (No. *1* *Johns Hopkins Hospital* St., *21* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Gerome Washington*
(Residence in Baltimore: No. *302 S. Fremont Ave* St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, <i>Male</i>	4-COLOR OR RACE, <i>Black</i>	5-Single, Married, Widowed, or Divorced, (Write the word.) <i>Married</i>
6-DATE OF BIRTH, <i>July 5</i> 1922 (Month) (Day) (Year)		
7-AGE, <i>4</i> yrs. <i>1</i> mos. <i>1</i> ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work, <i>Child of</i> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE, (State or Country), <i>Baltimore</i>		
PARENTS.	10-NAME OF FATHER, <i>John Washington</i>	
	11-BIRTHPLACE OF FATHER, (State or Country), <i>Va</i>	
	12-MAIDEN NAME OF MOTHER, <i>Alice Austin</i>	
	13-BIRTHPLACE OF MOTHER, (State or Country), <i>Va</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *John Washington*
(Address) *302 S. Fremont Ave*

15-
NOV 8 - 1922

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 6* 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (Pneumococci)

(PM as Stropaine)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. S. Toller* M. D.
(Coroner.)

11-7-22 (Address) *508 E. North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Mt Auburn *Nov 8* 1922

20-UNDERTAKER, ADDRESS *114 W.*

Brown & Friedman & Schodens

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: No. *846 Tyson*ST.: *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *846 Tyson*

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *6* yrs. *6* mos. *6* ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(h) General nature of industry, business, or establishment in which employed (or employer)

(e) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

File

NOV 8 - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 7* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Nov. 1* 19*22*, to *Nov. 7* 19*22*that I last saw her alive on *Nov 6* 19*22*and that death occurred, on the date stated above, at *5 P.* m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage(duration) mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of *Nov 22*

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Samuel A. Bain*, M. D.19 (Address) *937 Madison Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

St Peter Cemetery
*Joseph A. Harrell**Nov 9* 19*22*
2319 E. Underly

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D-69030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D 69030

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2957 Frederick St. WARD)

2-FULL NAME

Catherine A. Poor

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

2757 Frederick St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

3 yrs. 7 mos. 13 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henry Skins

6 DATE OF BIRTH (month, day, and year)

June 24-1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

4

13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Co.

10 NAME OF FATHER

Thomas J. Jagers

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

August Engel

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Co.

14

Informant

(Address)

Henry S. Poor 2757 Frederick St.

15

NOV 2 - 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 5 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 17, 1917, to Nov 5, 1922,

that I last saw him alive on Nov 6, 1922,

and that death occurred, on the date stated above, at 4:40 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Specimen sent

(Signed) J. H. Jagers M. D.

, 19 (Address) 904 W. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baths Creek

DATE OF BURIAL

11/9 1922

20 UNDERTAKER

J. H. Jagers

ADDRESS

1215 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69031
PLACE OF DEATH

90269031
REGISTERED NO.

CITY OF BALTIMORE: (No. 1436 Riverside Ave. ST. 74 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Wolf

(a) RESIDENCE. No. 1436 Riverside Ave. ST. 74 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Margaret Wolf WIFE of

6 DATE OF BIRTH (month, day, and year) 11/3/32

7 AGE 84 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED None
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Henry Wolf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) 1436 Riverside Ave.

NOV 8 - 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/5/22.

17 I HEREBY CERTIFY, That I attended deceased from 11/3/22, 19 to 11/5/22, 19 that I last saw him alive on 11/5/22, 19 and that death occurred, on the date stated above, at 1.55 P.m.

The CAUSE OF DEATH* was as follows:
Myocarditis
Auricular Fibrillation

(duration) yrs. mos. ds.
CONTRIBUTORY Cardiac Nilitation
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Morris, M. D.
17, 1922 Address 1430 Riverside Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Call's Cem 11/8 1922

20 UNDERTAKER J. Fahy & Sons ADDRESS 1318 Light St.

MARGIN RESERVED FOR BINDER
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21--M&T—1500 Bks.

D69032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69032
58-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9158 1st

ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

David Hughes

(a) RESIDENCE NO.

915 S. 1st

ST. _____ WARD _____

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

James Davis

6 DATE OF BIRTH (month, day, and year)

July 23 1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

61

7

11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Wales.

10 NAME OF FATHER

Wm Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Wales

12 MAIDEN NAME OF MOTHER

Margaret Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Wales

14

Informant (Address)

James Davis Hughes
915 S. 1st

15

NOV 8 - 1922

ROBERT R. KRAUTER,
Registrar

Serial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 7 1922

17

I HEREBY CERTIFY, That I attended deceased from May 15 15, 1922, to Nov 7th, 1922, that I last saw him alive on Nov 7th, 1922, and that death occurred, on the date stated above, at 5 30 p.m. The CAUSE OF DEATH* was as follows:

Pericarditis Aneuria

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood

(Signed)

Dargone, M. D.

Address) 1011 St. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park Cem

DATE OF BURIAL

Nov 10 1922

20 UNDERTAKER

John Vellrich

ADDRESS

2008 Orleans

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

069033

HEALTH DEPARTMENT—CITY OF BALTIMORE

069033

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 313 So. Central av. St. 3 Ward)

Registered No. C.

2-FULL NAME

(Residence in Baltimore: No. 313 So. Central av. St. 3, yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, white
5-Single, Married, Widowed, or Divorced, Single

6-DATE OF BIRTH, Jan 22, 1875
(Month) (Day) (Year)

7-AGE, 47 yrs. 9 mos. 15 ds.
8-LESS than 1 day, hrs. or min.?

9-OCCUPATION:
(a) Trade, profession, or particular kind of work, Millwright
(b) General nature of industry, business, or establishment in which employed (or employer).

10-BIRTHPLACE, (State or Country), Md

11-NAME OF FATHER, Peter H. Phillippi

12-BIRTHPLACE OF FATHER, (State or Country), Germany

13-MAIDEN NAME OF MOTHER, Annie R. Ralscher

14-BIRTHPLACE OF MOTHER, (State or Country), Germany

15-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Louise Holle

(Address) 3322 Frederick Ave

16-NOV 8 - 1922 ROBERT R. KRAUTER,

Filed 1922 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 6, 1922
(Month) (Day) (Year)

17-I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy, or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy at once
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thro. 13. Norton
(Signed) Nov. 6, 1922 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Trinity Church, Nov 9, 1922

20-UNDERTAKER, ADDRESS, Cliff Schmitt 216 May

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Greenmount Ave. ST. 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Ann May(Residence in Baltimore: No. 1329 Homewood Ave St. 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female4-COLOR OR RACE White5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, March, 1 (Month) (Day) (Year)7-AGE, 76 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work House wife(b) General nature of industry, business, or establishment in which employed (or employer) 0379-BIRTHPLACE, (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Patrick Reilly11-BIRTHPLACE OF FATHER (State or Country), Ireland12-MAIDEN NAME OF MOTHER Bridget Liddy13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose A. Maher(Address) 1200 Greenmount Ave

Filed

191

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, November, 6, 1922 (Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from July 15 1922, to Nov. 6th 1922, that I saw her alive on Nov 6th 1922, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

General sepsis - (from Senile gangrene of both feet of 4 months duration) (Duration) yrs. mos. ds. 3CONTRIBUTORY (Secondary) Atherosclerosis from history (Duration) 15 yrs. mos. ds.(Signed) Wm. A. Geraghty M. D.11/7, 1922 (Address) 203 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, CatholicDATE OF BURIAL, Nov 9, 192220-UNDERTAKER, H. E. WiedefeldADDRESS 914 Greenmount Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 Homewood Ave ST.; 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Toner(Residence in Baltimore: No. 1136 Homewood Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, Dec 4, 1865

(Month)

(Day)

(Year)

7-AGE,

56 yrs. 11 mos. 4 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Clerk(b) General nature of industry, business, or establishment in which employed (or employer) 1099-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Bernard Toner11-BIRTHPLACE OF FATHER (State or Country) Ireland12-MAIDEN NAME OF MOTHER Sarah Cannon13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Lucy(Address) 1136 Homewood Ave

15-

NOV 8-1922

Filed

191

ROBERT R. KRAUTER,Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH November 8, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from October 20 1922, to Nov 8th 1922,that I saw him alive on November 7 1922, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Abdominal Carcinomatosis
(General)(Duration) 1 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) Hypertrophic Cerebrovascular Disease(Duration) 3 yrs. 0 mos. 0 ds.(Signed) Wm. R. Graghty M. D.Nov 8, 1922 (Address) 203 E. Preston St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, CathedralDATE OF BURIAL, Nov. 11, 1922

20-UNDERTAKER

ADDRESS

H. C. Windfeld 914 Green Mt AveWRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks

Probably in Sigmoid ~~Colon~~

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

<i>Abortion,</i>	<i>Cellulitis,</i>	<i>Childbirth,</i>	<i>Convulsions,</i>
<i>Hæmorrhage,</i>	<i>Gastritis,</i>	<i>Erysipelas,</i>	<i>Meningitis,</i>
<i>Gangrene,</i>	<i>Miscarriage,</i>	<i>Necrosis,</i>	<i>Peritonitis,</i>
<i>Phlebitis,</i>	<i>Pyæmia,</i>	<i>Septicæmia,</i>	<i>Tetanus.</i>

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (if induced), whether death is directly or indirectly due to the same.

1926-11-8 MON
B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH *Woman's Hospital*
CITY OF BALTIMORE: (No. *Lofoyet & Johns* ST., *13* WARD)
2. FULL NAME *Walter Baby Boggs Jr*
(a) RESIDENCE No. *28 Palmdale Ave* WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. *159-20.69036*
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *✓*

6 DATE OF BIRTH (month, day, and year) *Oct 17-1922*

7 AGE Years Months Days If LESS than 1 day, hrs or min.
0 0 21

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *✓*

(b) General nature of industry, business, or establishment in which employed (or employer) *✓*

(c) Name of employer *✓*

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *MD*

10 NAME OF FATHER *Walter J Boggs*

11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *MD*

12 MAIDEN NAME OF MOTHER *Edna Brown*

13 BIRTHPLACE OF MOTHER (city or town) *Baltimore* (State or country) *MD*

14 Informant *Walter J Boggs* (Address) *28 Palmdale Ave*

15 *Robert P. Harrison*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *11-7-1922*

17 I HEREBY CERTIFY, That I attended deceased from *10-17-22*, to *11-7-22*, that I last saw him alive on *11-7-22*, and that death occurred, on the date stated above, at *12:10 p.m.*
The CAUSE OF DEATH* was as follows:
Intestinal hemorrhage.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *Pyloric Stenosis.*

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *11-6-22*

Was there an autopsy? *no*

What test confirmed diagnosis? *clinical findings*

(Signed) *R. J. Pyle* M. D.

19 (Address) *Woman's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Clary's Cem. Greenwood 9th 1922

20 UNDERTAKER

Henry Jenkins & Son Co

ADDRESS

Orchard Hill

A. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—MAT—1500 Dks.

10.69037

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.69037

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 S. Ann ST., 2 WARD)

2-FULL NAME

Frank J. Helinski

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No. 618 S. Ann ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11, 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Joseph Helinski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Julie Sobus

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant (Address) Joseph Helinski 618 S. Ann St.

15 Filed 1922 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7 1922

17

I HEREBY CERTIFY, That I attended deceased from November 7, 1922, to November 7, 1922.

that I last saw him alive on November 7, 1922.

and that death occurred, on the date stated above, at 8:50 p. m.

The CAUSE OF DEATH* was as follows:

Dementia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Convulsion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Inflammation of the gum

(Signed) J. J. L. M. D.

19 (Address) 722 S. Ann St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Stanislaus, Cal.

Nov 9 - 1922

20 UNDERTAKER

ADDRESS

M. J. Sadownski

705 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Hks.

10.69038

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.69038

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5102 York Road ex. 27 WARD)

2-FULL NAME Rebecca Arthur Ball

(a) RESIDENCE NO. 5102 York Road ex. 27 WARD

(Usual place of abode)
Length of residence in city or town where death occurred 79 yrs. 10 mos. — ds. (If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bartholomew Ball

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1843

7 AGE Years 79 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER John Arthur

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dublin, Ireland

12 MAIDEN NAME OF MOTHER Bridget Verlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dublin, Ireland

14 Informant R. Louis Ball (Address) 5102 York Road

15 Filed Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7th 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1922 to Nov 7th 1922, that I last saw her alive on Nov 27th 1922, and that death occurred, on the date stated above, at 8:15 A. M.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Salivary gland disease

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) E. H. Duncan M. D.

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Mary's Cemetery, Govans 11/9 1922

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER Henry W. Mears & Son 805 N. Calvert

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

2-FULL NAME

Mr. Walter J. Dulin.

(a) RESIDENCE NO.

Madisonville, Kentucky

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced

HUSBAND of
or WIFE of

Mrs. Jean Glen. (sister)

6 DATE OF BIRTH (month, day, and year) May 2, 1863.

7 AGE Years 59 Months 6 Days 6 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

" "

(c) Name of employer

" "

9 BIRTHPLACE (city or town) (State or country)

Kentucky.

10 NAME OF FATHER Robert S. Dulin.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

" "
Kentucky.

12 MAIDEN NAME OF MOTHER

Mary Clement.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

" "
Georgia.

14

Informant (Address)

JOHNS HOPKINS HOSPITAL
Records

15

Filed

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1922

17

I HEREBY CERTIFY That I attended deceased from Oct. 24, 1922 to Nov. 8, 1922.

that I last saw him live on Nov. 8, 1922,

and that death occurred, on the date stated above, at 9:57 a.m.

The CAUSE OF DEATH* was as follows:

Emaciation, secondary
anemia.

(duration) 8 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Exhaustion psychosis

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? No special test

(Signed) W. A. Corman, M. D.

Nov. 8, 1922 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

MADISONVILLE, KENTUCKY

DATE OF BURIAL

11/8/22

20 UNDERTAKER

H. E. Hughes 424 N Broadway

Burial Permit Clerk

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1143 Mc Elderry ST. 5 WARD)

2-FULL NAME Anna Harris

(a) RESIDENCE. No. 1143 Mc Elderry

(Usual place of abode)

Length of residence in city or town where death occurred

Yrs.

Mos.

ST.,

WARD.

(If nonresident give city or town and State)

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Fe

4 COLOR OR RACE

B

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

John Harris

6 DATE OF BIRTH (month, day, and year)

55 years.

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

55

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant

E. Bryan

(Address)

1631 Orleans St

19

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-7-1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 4, 1922, to Nov 4, 1922,

that I last saw him alive on Nov 4, 1922,

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) J. H. Bonhater, M. D.

117, 1922 (Address) 733 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

mt auburn cemetery nov 9 19

20 UNDERTAKER

Edward Bryan arleone

ADDRESS 1631 st

B. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec. 1-10-21-MAT-1500 Bks.

D. 69041 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 69041

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 806 St. 36th St. ST. 13 WARD

2-FULL NAME

(a) RESIDENCE No. 806 St. 36th St. ST. 13 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23-1859

7 AGE Years 63 Months 2 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Sadie C. Harper (Address) 806 St. 36th St.

15 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6- 19 22

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1922, to Nov. 6, 1922, that I last saw him alive on Nov 6, 1922,

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows: Chronic myocarditis + nephritis

CONTRIBUTORY (Secondary) arterio-sclerosis (duration) 4 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. R. W. M. D.

Nov 7, 1922 (Address) 865 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

St. Mary's (Hampton) Nov. 9, 1922

20 UNDERTAKER Horace H. Burque 363 Kall St.

12.69042

HEALTH DEPARTMENT—CITY OF BALTIMORE

12.69042

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3606 E Pratt St.; 129 WARD)

REGISTERED NO. C

2-FULL NAME

Richard P. Wilkins

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 3606 E Pratt St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male
4-COLOR OR RACE, White
5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married6-DATE OF BIRTH, May 3rd, 1866
(Month) (Day) (Year)7-AGE, 62 yrs., 6 mos., 3 ds.
If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work, Painter
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), City

10-NAME OF FATHER, Richard P. Wilkins Sr.

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Lillian Wilkins

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lillian Wilkins

(Address) 3606 E Pratt St.

15- Robert P. Harrison, 191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 11/7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 191, to 191, that I saw h alive on 191, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acc. Pulm. Disease and Hypertension
(Duration) yrs. mos. ds.CONTRIBUTORY (Secondary) Myocardial Infarction
(Signed) W. S. Little, M. D.
(Address) 3323 E. Pratt St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel DATE OF BURIAL, Nov. 10, 1922

20-UNDERTAKER, Peter Moolan ADDRESS, Eastern

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1922

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.69044 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *1000* St. *26* Ward)

2-FULL NAME

(Residence in Baltimore: No. *1000* St.; yrs. *26* mos. *6* ds.)

Registered No. C. *20.69044*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH. (Month) *1* (Day) *1* (Year) *1922*

7-AGE *46* yrs. *4* mos. *6* ds. If LESS than 1 day, hrs. or min. *2*

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Stewart on hand* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). *Pa.*

10-NAME OF FATHER. *John*

11-BIRTHPLACE OF FATHER. (State or Country). *Pa.*

12-MATERN NAME OF MOTHER. *John*

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Informant *Mr. Julia Hammond*
(Address) *688 Hudson St. N.Y.*

15- Robert P. Harrison,
Filed 1922 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Nov 6 27*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular heart disease
arteriosclerosis
hypertension
myocardial infarction
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) *John* M. D. (Coroner.) 1922 (Address) *1000*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

New York City *Nov 11 1922*

20-UNDERTAKER. ADDRESS

C. A. Wiedefeld *301 E 22 St*

13—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.69045 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.69045

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 M. Henry St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 714 M. Henry St.; yrs. 35 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX 7 4-COLOR OR RACE, W. 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, May 12 1922 (Month) (Day) (Year)

7-AGE, 68-5 25 If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Ireland

PARENTS. 10-NAME OF FATHER, Timothy Holleran 11-BIRTHPLACE OF FATHER, Ireland 12-MAIDEN NAME OF MOTHER, Hayes 13-BIRTHPLACE OF MOTHER, Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Peter P. Newkell (Address) 714 M. Henry St.

15. Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 6 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Mitral Stenosis

CONTRIBUTORY (Secondary) Duration, yrs. 2 mos. 2 ds. (Signed) Geo. Clinton Bladen, M. D. (Address) 192 M. Henry St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Olivet Cem. DATE OF BURIAL, Nov. 9 1922

20-UNDERTAKER, Sept B. Cook ADDRESS, 1003 N. Balt. St.

69046 HEALTH DEPARTMENT—CITY OF BALTIMORE 69046

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 N. Eutaw Street ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

(a) RESIDENCE No. 1102 N. Eutaw Street

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Annice M. Devall

6 DATE OF BIRTH (month, day, and year) Unknown 1848

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

74

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Horse-Shoening

(b) General nature of industry, business, or establishment in which employed (or employer)

Business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

New Jersey

10 NAME OF FATHER

Chas Devall

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New Jersey

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

PARENTS

14 Informant (Address)

Annice M. Devall 1102 N. Eutaw St.

15

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 1922

17

I HEREBY CERTIFY, That I attended deceased from

March 13, 1921, to Nov. 6, 1922

that I last saw him alive on " " 1922

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY Cerebral hemorrhage (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E. du P. Cooldhan, M. D.

11/7/22 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Cathedral Cemetery

11/9 1922

20 UNDERTAKER

ADDRESS

Chas. J. Evans & Son 118 Mont Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

GV 8-1922 Filed

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

069047

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

069047

X164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 265 S. Durham ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Huber.

(a) RESIDENCE NO. 5209 Main St. Allington WARD New York.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male White Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown.

6 DATE OF BIRTH (month, day, and year)

1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

74

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany.

10 NAME OF FATHER

Albert Huber

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Unknown (Germany)

14

Informant

(Address)

Mrs. James G. Maguire

5209 Main St.

15

NOV 9 - 1922

ROBERT H. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 6 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1st, 1922, to Nov 6, 1922,

that I last saw him alive on Nov 5, 1922,

and that death occurred, on the date stated above, at 11:00 A. M.

The CAUSE OF DEATH* was as follows:

Senile thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. H. H. M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

Mt. Carmel Bur

20 UNDERTAKER

H. Sanders Sons

DATE OF BURIAL

Nov 9 1922

ADDRESS

1710 E. 1st St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Roselia Ave* ST. *Hamilton* WARD)2-FULL NAME *August J. Glazel Jr*(a) RESIDENCE. NO. *Roselia Ave* ST. *Hamilton* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *16* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

4 COLOR OR RACE *Male*5 Single, Married, Widowed, or Divorced (Write the word) *Married*

(a) If married, widowed, or divorced

HUSBAND of *Violet E. Glazel* (or) WIFE of6 DATE OF BIRTH (month, day, and year) *12-25-1893*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *29 10 18*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Machinist*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore*10 NAME OF FATHER *August J. Glazel*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*12 MAIDEN NAME OF MOTHER *Gertrude Kahler*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*14 Informant *Violet E. Glazel* (Address) *Roselia Ave Hamilton*15 Filed *NOV 9-1922* REGISTRAR *ROBERT R. KRAUTER*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 7 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*June 5, 1922, to Nov 7, 1922*that I last saw him alive on *Nov 7, 1922*and that death occurred, on the date stated above, at *10:30 P.M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *1* yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) *1* yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of *—*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Howard W. Jones*, M. D.11-9-22 (Address) *222 August Ave*

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Parkwood*DATE OF BURIAL *11/10/22*20 UNDERTAKER *Wm Cook*ADDRESS *502 E. North*

PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Jones August 1922

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Hks.

069049

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-000069049

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. #33. W. West St.

ST., 22. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME John T. Hutson Jr.

(a) RESIDENCE NO. #33. W. West St.

ST., 22. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 3 mos. 8

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male. White. Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July, 30, 1913.

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 9 3 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER John T. Hutson, Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Couch.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant John T. Hutson, Sr. (Address) #33. W. West St.

15 Filed NOV 9 - 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/7 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 30 " 1922 to Nov. 7 " 1922.

that I last saw him live on Nov. 6 " 1922.

and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

Signed Harry Heibel, M.D.

11/7, 1922 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Cedar Hill Cemetery.

20 UNDERTAKER

Mrs. J. E. Evans & Sons, 1428 S. Charl St.

DATE OF BURIAL

November 10, 1922

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

69050

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 W Franklin ST. 70 WARD)

2-FULL NAME Emma Menkel

(a) RESIDENCE. NO. 1909 W Franklin ST. 70 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

all her life

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced (write the word)

widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

George Menkel

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

67

4

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balt

10 NAME OF FATHER

John C. Ritzins

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Emma Ritzins

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14 Informant (Address)

Charles Menkel (Son) 1909 W Franklin St

15 Filed

19

ROBERT R. KRAUTER Registrar

NOV 9 - 1922

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1922, to Nov 8, 1922, that I last saw her alive on Oct 7, 1922, and that death occurred, on the date stated above, at 7:20 a.m. The CAUSE OF DEATH* was as follows:

Edema of the Brain and (Uremia)

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) yrs. mos. 14 ds. Myocardial Insufficiency (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph H. Garter, M. D.

10819 (Address) 1123 Popper Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Linden Park

Nov 10 1922

20 UNDERTAKER

ADDRESS

Josiah Syfer 1600 North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: No. 823 N. Bond ST.: 7 WARD) REGISTERED NO. 101-0069051
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Halland

(a) RESIDENCE. No. 823 N. Bond ST.: _____ WARD. _____
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Hilland

6 DATE OF BIRTH (month, day, and year) Sept 6, 1862

7 AGE 60 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Prince George Co Md
(State or country)

10 NAME OF FATHER William Taylor

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Annie Young

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14 Informant Sarah Moore
(Address) 823 N. Bond St

15 Filed NOV 9 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-5 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1922 to Nov 5, 1922
that I last saw her alive on Nov 5, 1922
and that death occurred, on the date stated above, at _____ m.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas M. D.

11-8, 1922 (Address) 822 N. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Ashbury Cemetery Nov 9, 1922

20 UNDERTAKER ADDRESS

Mrs R.A. Elliott 1725 Ashland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

N. B. — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. — 1-10-21 — M&T — 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 627 Glenwood ST., 27 WARD)

2. FULL NAME

(a) RESIDENCE No. 627 Glenwood ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 0 mos. 0 ds.

How long in U. S., if of foreign birth? 2 yrs. 0 mos. 0 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 14, 1852

7 AGE Years 70 Months 22 Days 22 If LESS than 1 day, 0 hrs. 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER Joshua H. Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Joyosa C. Ross

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Emma J. Peters (Address) 627 Glenwood

15 NOV 3 - 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 19 22

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Nov 8, 1922, that I last saw her alive on Nov 7, 1922, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) old age (duration) yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) P. O. Heavis M. D.

1922 (Address) 1600 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Holy Redeemer

DATE OF BURIAL Nov 10, 1922

20 UNDERTAKER Jirkler & Jirkler

ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state Exact statement of OCCUPATION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 1-10-21-MAT 1500 Bks.

269053 HEALTH DEPARTMENT—CITY OF BALTIMORE 269053
31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 N. Gay ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alberta V. Slater

(a) RESIDENCE NO.

1440 N. Gay

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Joe F. Slater

6 DATE OF BIRTH (month, day, and year)

March 26, 1857

7 AGE

65

7

18

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Ind.

10 NAME OF FATHER

Jesse S. Kuler

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Martha E. Kuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ind.

14

Informant (Address)

Joe F. Slater 1440 N. Gay St.

15

Filed

NOV 9 - 1922 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 15th, 1922, to Nov 8th, 1922,

that I last saw her alive on Nov 8th, 1922,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

Pulmonary T.B.

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & physical

(Signed) D. Anne Miller, M. D.

, 19 (Address) 1506 3 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR RE-

MOVAL Druid Ridge

DATE OF BURIAL

Nov 11 1922

20 UNDERTAKER

Junkler & Junkler No 1222 No 3097

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Ills.

Gorfine
D69054 HEALTH DEPARTMENT—CITY OF BALTIMORE *D69054*

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1612 W. Saratoga* ST. *19* WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1612 W. Saratoga* St. *27* yrs. *129* mos. *19* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE. *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. *Married* (Write the word.)

6-DATE OF BIRTH. *unknown, 1872* (Month) (Day) (Year)

7-AGE. *50* yrs. *-* mos. *-* ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. *Grocery* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Russia*

10-NAME OF FATHER, *Sholam Gorfine*

11-BIRTHPLACE OF FATHER (State or Country), *Russia*

12-MAIDEN NAME OF MOTHER *Sheba Gorfine*

13-BIRTHPLACE OF MOTHER (State or Country), *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Dr. Kader*

(Address) *2206 E. Eustaw Pl.*

15- *NOV 9 - 1922* *ROBERT H. KRAUTER,*

Filed *191* *Burial Permit Registrar.*

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 9th 1922* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Apr 22 1922*, to *Nov 8 1922*, that I saw him alive on *Nov 8th 1922*, and that death occurred, on the date stated above, at *19* m.

The CAUSE OF DEATH* was as follows:

Acute paronychia
nephritis
(Duration) *7* yrs. *16* mos. *16* ds.

CONTRIBUTORY *Acute cardiac*
(Secondary) *dilatation* (Duration) *Instant death*

(Signed) *Benj. Kader* M. D.
....., 191... (Address) *2206 Eustaw Pl.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *7* yrs. *16* mos. *16* ds. In the State *19* yrs. *129* mos. *19* ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Suber Rosehall* DATE OF BURIAL, *11/9 1922*

20-UNDERTAKER *Jack Lewis 1437* ADDRESS *5220 1st St*

360
N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

069055- HEALTH DEPARTMENT—CITY OF BALTIMORE 069055
8161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2607 Kuper ST., WARD)

2-FULL NAME

(a) RESIDENCE NO. 2607 Kuper ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md. (State or country)

10 NAME OF FATHER Richard Carroll Kuper

11 BIRTHPLACE OF FATHER (city or town) Balto Md. (State or country)

12 MAIDEN NAME OF MOTHER Helen Marie Kuper

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Richard Carroll Kuper (Address) 2607 Kuper St.

15 NOV 9 - 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 7, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1922, to Nov. 7, 1922, that I last saw him alive on Nov. 7, 1922, and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity.
Child only lived 10 minutes
5 months gestation yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Thos. F. Swann, M. D.

11/7, 1922 (Address) 2878 Harford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

HOPKINS HOSPITAL

NOV 8 1922

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 E. Preston St.ST.: 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Cain(a) RESIDENCE. No. 733 E. Preston St.

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ann E. Cain6 DATE OF BIRTH (month, day, and year) Aug 19-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
73	10	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)10 NAME OF FATHER James Cain11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)12 MAIDEN NAME OF MOTHER Mary McInnis13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14

Informant Mrs. Ann E. Cain
(Address) 733 E. Preston St.Filed Nov 9-1922ROBERT R. KRAUTER,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 8-192217 I HEREBY CERTIFY, That I attended deceased from Oct 18-1922, to Nov 8-1922,
that I last saw him alive on Nov 7-1922and that death occurred, on the date stated above, at 12:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
(duration) 2-4 yrs. mos. ds.CONTRIBUTORY Chronic Bronchitis
(Secondary) (duration) 20-3 yrs. mos. ds.18 Where was disease contracted
if not at place of death?Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Stethoscope
(Signed) Mary F. Vaughan M. D.119. 1922 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery11/10 1922

20 UNDERTAKER

ADDRESS

Chas. F. Evans & Son-118 W. Mt. Royal Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 3210 Anchenbury Terrace
CITY OF BALTIMORE: (No. 3210 ST. 3 WARD) REGISTERED NO. C 129
2-FULL NAME Mary Estelle Wolf (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
(Residence in Baltimore: No. 3210 Anchenbury Per yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female 4-COLOR OR RACE W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married
6-DATE OF BIRTH, May 9th, 1872
(Month) (Day) (Year)
7-AGE, 50 yrs. 5 mos. 18 ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work Home
(b) General nature of industry, business, or establishment in which employed (or employer) work
9-BIRTHPLACE, (State or Country), Bald. Ind.
PARENTS.
10-NAME OF FATHER, Rhinehart List
11-BIRTHPLACE OF FATHER (State or Country), Germany
12-MAIDEN NAME OF MOTHER Mary E. Kelly
13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lewis C. Wolf
(Address) 3210 Anchenbury Per

15-

Filed NOV 9-1922 191... ROBERT R. KRAUTER, Registrar.
Burial Permit 1213

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1921, to Nov. 7, 1922, that I saw her alive on Nov. 7, 1922, and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

myocarditis
diffuse nephritis
(Duration) 1 yrs. 1 mos. 1 ds.

CONTRIBUTORY Acute dilatation of
Secondary

(Signed) R. C. Metzger M. D.
Nov. 9, 1922 (Address) 1903 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Lorraine Cemetery Nov. 10, 1922

20-UNDERTAKER ADDRESS

W. H. Rouse 7238 W. North Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

269058 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1928 Smith Hill Ave 4 ST. 12 WARD)

REGISTERED No. C

2-FULL NAME Henry J. Thomas

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1928 Smith Hill Ave 4 ST. 12 yrs. 1 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, colored 5-SINGLE, married, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, Oct 6, 1858 (Month) (Day) (Year)

7-AGE, 64 yrs. 1 mos. 4 ds. If LESS than 1 day,hrs. ormin.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, steward (b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Henry Thomas

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Elizabeth Johnson

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cliff Thomas

(Address) 1928 Smith Hill Ave

15- NOV 9 - 1922 191... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 7, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1 1922, to Nov. 7 1922, that I saw him alive on Nov. 6 1922, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 4 yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration) 2 yrs. 1 mos. 4 ds.

(Signed) Cliff Thomas M. D.

191 (Address) 315 McArthur St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death 1 yrs. 1 mos. 4 ds. In the State 1 yrs. 1 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn DATE OF BURIAL, Nov. 10, 1922.

20-UNDERTAKER, James H. Deaver Jr ADDRESS 2002 McCall St Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 N. 2nd St. WARD 71)

2-FULL NAME

Magdalena Erbe

(a) RESIDENCE NO.

612 N. 2nd St.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female whiteMarried

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Conrad Erbe

6 DATE OF BIRTH (month, day, and year)

Aug 27 1853

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

69 2 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Hofmann

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Margaretha Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Conrad Erbe
612 N. 2nd St.

15

Filed

19

WILLIAM R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 4, 1922, to Nov 8, 1922.that I last saw him alive on Nov 7, 1922.that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Capillary
bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Parenchymatous
nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date ofWas there an autopsy? noWhat test confirmed diagnosis? Clinical(Signed) Conrad Erbe, M. D.11/8, 1922 Address 175 E. Pennsylvania St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park CemeteryNov 10 1922

20 UNDERTAKER

ADDRESS

for Frederickson Son217 S. Park

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

869060 HEALTH DEPARTMENT—CITY OF BALTIMORE 128-2 69060.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1303 Upstn St. 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1303 Upstn St. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day.

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.
(State or Country).

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER.
(State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER.
(State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Harrison M. D. (Coroner.)

Nov. 9, 1922 (Address) 2802 E. ...

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

MT Auburn Nov 8, 1922

20-UNDERTAKER

ADDRESS

Nancy Easton Pa ave

NOV 9 - 1922

ROBERT R. KRUTER Registrar

Burial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *719 Baker*)ST. *15* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Robert Green*(a) RESIDENCE, No. *719 Baker*

ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Maria Green*6 DATE OF BIRTH (month, day, and year) *Jan. 1 - 1962*

7 AGE

60

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Marble polisher

(b) General nature of industry, business, or establishment in which employed (or employer)

*Employed in
Marble factory*

(c) Name of employer

*Emmanuel Co.*9 BIRTHPLACE (city or town)
(State or country)*West Indies*

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

West Indies

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

West Indies

14

Informant

(Address)

*Maria Green
719 Baker St.*

15

Filed

NOV 9 - 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 7* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 27, 19*22*, to *Nov. 7*, 19*22*,that I last saw him alive on *Nov 6*, 19*22*,and that death occurred, on the date stated above, at *3-25 P. m.*

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage(duration) yrs. mos. *1* ds.CONTRIBUTORY
(Secondary)*acute hepatic congestion*(duration) yrs. mos. *12* ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

none

(Signed)

Chas. L. McFarland

M. D.

, 19

(Address) *2410 Edmondson Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Ambrose

20 UNDERTAKER

*David Eastwood**Nov 9 1922*

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE No.

(Usual place of abode)

Length of residence in city or town where death occurred

25 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female white

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Robert P. Hyland

6 DATE OF BIRTH (month, day, and year)

Feb 18 1879

7 AGE

43

Years

Months

Days

If LESS than 1 day, hrs. or min.

9

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Altoona, Pennsylvania

10 NAME OF FATHER

Thomas J. Trece

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Pennsylvania

12 MAIDEN NAME OF MOTHER

Anna P. Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pennsylvania

14

Informant (Address)

Robert P. Hyland 331 N. Delaware Ave.

15

NOV 9 - 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1922, to Nov. 8, 1922,

that I last saw him alive on Nov. 8, 1922,

and that death occurred, on the date stated above, at 3:45 A. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Auricular Fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? PS & S

(Signed)

J. J. Krager, M. D.

19

(Address)

St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

United Ameteries Baltimore Nov 10 1922

20 UNDERTAKER

ADDRESS

Fred L. Schmitt Sons Baltimore

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Murray Hospital* ST. *27* WARD)

2-FULL NAME

James Hoban

(a) RESIDENCE NO.

1111 Wash. Seminary Det. Wash. D.C.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 19 - 1913

7 AGE

Years

Months

Days

If LESS than 1 day, hrs.

or min.

*9**2**10*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Pradshaw Md.

10 NAME OF FATHER

Frank Hoban

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Md.

12 MAIDEN NAME OF MOTHER

Caroline French

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant (Address)

*John G. Gowler
Washington D.C.*

15

Filed - 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 9, 1922*

17

I HEREBY CERTIFY That I attended deceased from

*Nov. 8, 1922 - 9 P.M. Nov. 9, 1922.*that I last saw him alive on *Nov. 8, 1922.*and that death occurred, on the date stated above, at *2:09* m.

The CAUSE OF DEATH* was as follows:

Epidemic Cerebro Spinal Meningitis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Coronary failure

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Edwin E. Maynard*, M. D.

11/9/22 (Address)

1138 E. North St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Washington D.C. *11/9/22*

20 UNDERTAKER

ADDRESS

W. J. Tuttle & Sons - Prince Georges

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

869064

HEALTH DEPARTMENT—CITY OF BALTIMORE

869064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: 1606 So. 3rd St. 76 Ward

2-FULL NAME

Frank Schultze

1606 So. 3rd St.

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. St.; yrs.; mos.; ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

white

5-Single, Married, Widowed, or Divorced. (Write the word.)

Unknown

6-DATE OF BIRTH

Unknown

7-AGE

about 54 yrs. - mos. - ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Labour

(b) General nature of industry, business, or establishment in which employed (or employer).

640

9-BIRTHPLACE, (State or Country).

Unknown

PARENTS.

10-NAME OF FATHER.

Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

Unknown

12-MAIDEN NAME OF MOTHER.

Unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15-NOV 9 - 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

Registrar.

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 2nd 1922

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry find that said deceased came to his death topsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) Thos B. Norton M. D.

Coroner.

1606 So. 3rd St. Curtis Bay, Md.

*State the Disease Causing Death or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, PUBLIC CEMETERY.

DATE OF BURIAL, NOV 9 - 1922

20-UNDERTAKER, Commissioner Health,

ADDRESS

Per, Wm. E. WOODALL.

PHYSICIAN should state EXACTLY. Exact statement of Cause of Death in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks

(William Bernard Bayles)

1069065 HEALTH DEPARTMENT—CITY OF BALTIMORE 1069065

CERTIFICATE OF DEATH. X 49 ✓

1-PLACE OF DEATH *Mayland General Hospital* REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. _____ ST. _____ WARD _____)

2-FULL NAME *William B Bayles*

(a) RESIDENCE NO. _____ ST. _____ WARD _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. _____ mos. *14* ds. _____ How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH	
3 SEX <i>male</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced, (write the word) <i>Married</i>		16 DATE OF DEATH (month, day, and year) <i>Nov 9 1922</i>	
5a If married, widowed or divorced HUSBAND of (or) WIFE of <i>Juliett A Bayles</i>				17 I HEREBY CERTIFY That I attended deceased from <i>Oct. 25</i> , 19 <i>22</i> , to <i>Nov. 9</i> , 19 <i>22</i> , that I last saw him alive on <i>Nov. 9</i> , 19 <i>22</i> , and that death occurred, on the date stated above, at <i>2.30 P.</i> m.	
6 DATE OF BIRTH (month, day, and year) <i>July 27. 1849</i>				The CAUSE OF DEATH* was as follows: <i>Carcinoma of Prostate gland.</i>	
7 AGE Years <i>73</i> Months <i>3</i> Days <i>12</i> If LESS than 1 day, _____ hrs. or _____ min.					
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <i>Retired</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>Rail Road Employee</i> (c) Name of employer _____				CONTRIBUTORY (Secondary) <i>Chronic Hypertension</i> (duration) <i>2</i> yrs. _____ mos. _____ ds. <i>acute bronchitis</i> (duration) _____ yrs. _____ mos. <i>7</i> ds.	
9 BIRTHPLACE (city or town) _____ (State or country) <i>Va</i>				18 Where was disease contracted if not at place of death? <i>at home</i>	
10 NAME OF FATHER <i>Bernard Bayles</i>				Did an operation precede death? <i>Yes</i> Date of <i>Oct 31-1922</i>	
11 BIRTHPLACE OF FATHER (city or town) _____ (State or country) <i>Va Md</i>				Was there an autopsy? <i>No</i>	
12 MAIDEN NAME OF MOTHER <i>Henrietta B. Lomden</i>				What test confirmed diagnosis? <i>Ames test Wilkerson</i> (Signed) _____, M. D.	
13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country) <i>Md</i>				(Address) <i>Med. General Hospital</i>	
14 Informant <i>Geo A Bayles</i> (Address) <i>Principis Terrace Md</i>				19 PLACE OF BURIAL, CREMATION OR REMOVAL <i>St Marks Chapel Cecil Co Md</i> DATE OF BURIAL <i>Nov 9 1922</i>	
15 <i>Nov 9 1922</i> Registrar <i>John O. Mitchell</i>				ADDRESS <i>120 W Fayette</i>	

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 213 H. H. Webster ST. 72 WARD

(Usual place of abode)				(If non-resident give city or town and State)			
Length of residence in city or town where death occurred	yrs.	mos.	ds.	How long in U. S., if of foreign birth?	yrs.	mos.	ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1922

I HEREBY CERTIFY, That I attended deceased from
Oct 20, 1927 to Nov 9, 1927

that I last saw h... alive on... 1932

and that death occurred, on the date stated above, at 5:00 m.

The CAUSE OF DEATH* was as follows:

C. B. Brant

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

... (duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?.....

Did an operation precede death? Yes Date of 12/1/68

Was there an autopsy? Yes

What test confirmed diagnosis? CT scan

(Signed) M. D.

11, 19 (Address) *Long...*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- MOVAL	DATE OF BURIAL
<p>1. <u>St. Mary's Catholic Church</u></p> <p>2. <u>St. Mary's Catholic Church</u></p> <p>3. <u>St. Mary's Catholic Church</u></p> <p>4. <u>St. Mary's Catholic Church</u></p> <p>5. <u>St. Mary's Catholic Church</u></p> <p>6. <u>St. Mary's Catholic Church</u></p> <p>7. <u>St. Mary's Catholic Church</u></p> <p>8. <u>St. Mary's Catholic Church</u></p> <p>9. <u>St. Mary's Catholic Church</u></p> <p>10. <u>St. Mary's Catholic Church</u></p> <p>11. <u>St. Mary's Catholic Church</u></p> <p>12. <u>St. Mary's Catholic Church</u></p> <p>13. <u>St. Mary's Catholic Church</u></p> <p>14. <u>St. Mary's Catholic Church</u></p> <p>15. <u>St. Mary's Catholic Church</u></p> <p>16. <u>St. Mary's Catholic Church</u></p> <p>17. <u>St. Mary's Catholic Church</u></p> <p>18. <u>St. Mary's Catholic Church</u></p> <p>19. <u>St. Mary's Catholic Church</u></p> <p>20. <u>St. Mary's Catholic Church</u></p>	<p>1. <u>1900</u></p> <p>2. <u>1900</u></p> <p>3. <u>1900</u></p> <p>4. <u>1900</u></p> <p>5. <u>1900</u></p> <p>6. <u>1900</u></p> <p>7. <u>1900</u></p> <p>8. <u>1900</u></p> <p>9. <u>1900</u></p> <p>10. <u>1900</u></p> <p>11. <u>1900</u></p> <p>12. <u>1900</u></p> <p>13. <u>1900</u></p> <p>14. <u>1900</u></p> <p>15. <u>1900</u></p> <p>16. <u>1900</u></p> <p>17. <u>1900</u></p> <p>18. <u>1900</u></p> <p>19. <u>1900</u></p> <p>20. <u>1900</u></p>

20 UNDERTAKER	ADDRESS
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Filed _____, 19____ J. HARRISON
Registrar

APR 16 1964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Pine Crest Sat. 6 atonsort City*)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1039 W. Lanvale*)St.: *83* yrs., *3* mos., *ds.*

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F.

4-COLOR OR RACE,

W.

5-SINGLE,

MARRIED, *Widow*

WIDOWED,

OR DIVORCED,

(Write the word.)

6-DATE OF BIRTH,

*Aug.**16**1837*

7-AGE,

*83**3**ds.*

If LESS than 1 day,

...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work *none*(b) General nature of industry, business, or establishment in which employed (or employer) *not*

9-BIRTHPLACE,

(State or Country), *Balto Md.*10-NAME OF FATHER, *Henry Spurrier*

11-BIRTHPLACE OF FATHER

(State or Country), *Balto Md.*

12-MAIDEN NAME OF MOTHER

unknown

13-BIRTHPLACE OF MOTHER

(State or Country), *unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Robt. Hallup*(Address) *2200 Mt. Royal*

15-

Filed

Robert P. Harrison

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

*Nov.**9**1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Jan 1922, to *Nov 9* 1922,that I saw her alive on *Nov 7* 1922,and that death occurred, on the date stated above, at *5:30 AM*.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast(Duration) *2* yrs., *2* mos., *ds.*CONTRIBUTORY (Secondary) *Exhaustion*(Duration) *2* yrs., *2* mos., *ds.*(Signed) *T. M. Harrison* M. D.*Nov 9, 1922* (Address) *826 W. Carroll St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death *ys.* *mos.* *ds.* In the State *ys.* *mos.* *ds.*

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

*London Park**Nov. 10, 1922*

20-UNDERTAKER

ADDRESS

*George J. Smith**1332 W. Hollen*

10.69068

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.69068

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2449 N Calvert

ST.:

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Vestella Ann Blake

(Residence in Baltimore: No.

2449 N Calvert

St.:

yrs. 4

mos.

ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE.

White

5-SINGLE.

WIDOWED

OR DIVORCED

(Write the word.)

Widow

6-DATE OF BIRTH.

March

4

1844

(Month)

(Day)

(Year)

7-AGE.

78

yrs.

8

mos.

4

ds.

IF LESS than 1 day.

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE.

(State or Country).

Essex Co. Va

10-NAME OF FATHER

Ephriam Besley

11-BIRTHPLACE OF FATHER

(State or Country).

Va

12-MAIDEN NAME OF MOTHER

Francis Baughman

13-BIRTHPLACE OF MOTHER

(State or Country).

Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Mrs M.B. Stromer

(Address)

2449 N Calvert

15-

Robert P. Harrison

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

10-DATE OF DEATH.

Nov

8

1922

(Month)

(Day)

(Year)

I HEREBY CERTIFY, That I attended deceased from

Oct 16 1922, to Nov 8 1922

that I saw her alive on Nov 8 1922

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Paralysis (left side)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Signed) R. P. Harrison M. D.

Nov 9, 1922 (Address) 2303 N Calvert

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

former or usual residence New York N. Y.

19-PLACE OF BURIAL OR REMOVAL.

Lorraine

DATE OF BURIAL.

Nov 10, 1922

20-UNDERTAKER

Richard H. Cury

ADDRESS 438 C. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.69069 HEALTH DEPARTMENT-CITY OF BALTIMORE 20.69069

CERTIFICATE OF DEATH

1 PLACE OF DEATH
CITY OF BALTIMORE (No. 2127 E. Monument ST. 4 WARD)
2-FULL NAME Margaret J. Thomas
(Residence in Baltimore: No. 624 N. Robinson St. 4 yrs. mos. ds.)

REGISTERED NO. C
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female
4 COLOR OR RACE white
5 SINGLE, MARRIED, WIDOWED OR DIVORCED widowed
6 DATE OF BIRTH Dec 22 1851
7 AGE 70
8 OCCUPATION Housewife
9 BIRTHPLACE Maryland
10 NAME OF FATHER William W. Erskine
11 BIRTHPLACE OF FATHER Maryland
12 MAIDEN NAME OF MOTHER Mary Wife Erskine
13 BIRTHPLACE OF MOTHER Maryland
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E. Spence
(Address) 624 N. Robinson St.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 7 1922
17 I HEREBY CERTIFY, That I attended deceased from Nov 1 1922 to Nov 7 1922
that I saw her alive on Nov 7 1922
and that death occurred, on the date stated above, at 7:30 a.m.
The CAUSE OF DEATH* was as follows:
Coronary Sclerosis
Contributory (SECONDARY) Cordial Paralysis
(Signed) William J. R. Smith M. D.
Nov 7 1922 (Address) 847 N. Howard St.
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted?
If not at place of death?
Former or usual residence
19 PLACE OF BURIAL OR REMOVAL Baltimore County
20 UNDERTAKER Wm. H. Hartley
DATE OF BURIAL Nov 10th 1922
ADDRESS 815 N. Washington

9-1922 Robert P. Harrison,
Burial Permit Clerk REGISTRAR

10.69070

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.69070

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

103 Beverly

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Franklin P Taylor

(a) RESIDENCE. No.

103 Beverly

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Katherine Taylor

6 DATE OF BIRTH (month, day, and year)

2.13.1871

7 AGE 57 Years 8 Months 26 Days

If LESS than
1 day, ... hrs.
or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Ship Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore

10 NAME OF FATHER

Samuel Taylor

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant

(Address)

Mrs Josephine Taylor
103 Beverly

15

Filed

Robert P. Taylor

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

11.9

1922

17

I HEREBY CERTIFY, That I attended deceased from

10/24, 1922, to 11.9, 1922,

that I last saw him alive on 11.9, 1922,

and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)Typhoid Fever
5 weeks

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Huntington, M. D.

19 (Address) 102 E. Ford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cedar Hill

April 1922

20 UNDERTAKER

ADDRESS

Wm Cork

248 GME

PHYSICIANS should state EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

1922

10.69071 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.69071

CERTIFICATE OF DEATH
 1-PLACE OF DEATH
 City of BALTIMORE: (No. 1906 E. Fairmount St. 6 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
 2-FULL NAME Chas W. Cokeran
 (Residence in Baltimore: No. 1906 E. Fairmount St. 6 yrs. 26 mos. 167 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX M. 4-COLOR OR RACE White 5-Single, Married, Widowed, or Divorced, (Write the word.) Married
 6-DATE OF BIRTH July 31, 1883 (Month) (Day) (Year)
 7-AGE 39 yrs. 7 mos. 167 ds. If LESS than 1 day, hrs. or min.
 8-OCCUPATION:
 (a) Trade, profession, or particular kind of work. Commission
 (b) General nature of industry, business, or establishment in which employed (or employer). Merchant
 9-BIRTHPLACE, (State or Country). Eastern Shore Md.
 10-NAME OF FATHER Frank Cokeran
 11-BIRTHPLACE OF FATHER, (State or Country). Eastern Shore Md.
 12-MAIDEN NAME OF MOTHER Anna Matthews
 13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore Md.
 14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
 (Informant) Barbara Cokeran
 (Address) 1906 E. Fairmount St.
 15- Robert F. Harrison, Registrar.
 Filed 1922 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH Nov. 7, 1922 (Month) (Day) (Year)
 17- I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, (Inquest, autopsy or inquiry.)
 thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.
 The CAUSE OF DEATH* was as follows:
 Ill. Gas. (Suicide)
 (Duration) yrs. 4 mos. 4 ds.
 CONTRIBUTORY Asphyxia
 (Signed) Ed. Clinton P. Biddle, M. D. (Coroner)
 (Address) 143 N. 3rd St.
 *State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
 18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
 At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
 Where was disease contracted, if not at place of death?
 Former or usual residence.
 19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
 Oak Lawn Nov. 9, 1922
 20-UNDERTAKER ADDRESS
 Wendell J. Appled 300 S. Wash St.

W. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.69072 (Appolonia Karl) (KARL) 20.69072
HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 624 Melvale Ave. St. 9 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 624 Melvale Ave. St.; yrs. 4 mos.ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, (Month) (Day) (Year)

7-AGE, If LESS than 1 day,hrs. ormin.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant), (Address)

15- Robert F. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows:

(Duration)yrs.mos.ds.

CONTRIBUTORY (Secondary) (Duration)yrs.mos.ds. (Signed) (Coroner.) 1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death,yrs.mos.ds. In the State,yrs.mos.ds. Where was disease contracted, if not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 20-UNDERTAKER, ADDRESS

1922 Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.69073 (Scheiner) HEALTH DEPARTMENT—CITY OF BALTIMORE 10.69073

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 W. Camden St. 22 Ward)

Registered No. C.....

2-FULL NAME.

(Residence in Baltimore: No. 400 W. Camden St. life St.; yrs..... mos..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Don't Know

7-AGE, 72 about If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Don't Know (b) General nature of industry, business, or establishment in which employed (or employer), 087

9-BIRTHPLACE, (State or Country), Balto Md Don't Know

10-NAME OF FATHER, Don't Know

11-BIRTHPLACE OF FATHER, (State or Country), Don't Know

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER, (State or Country), Don't Know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Scheiner

(Address) 353 N. Broadway

15-

Filed, Robert P. Harrison, Registrar.

1922 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 9, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Don't Know

(Signed) H. H. Gansel M. D. (Coroner.)

11-9 1922 (Address) 11 W. Camden

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs..... mos..... ds. In the State, yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Western Mem. Nov 10th 1922

20-UNDERTAKER, ADDRESS 1034

G. Schlomacher

10.69074 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.69074

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO

2101 Bolton

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emma Johnson Fink

(a) RESIDENCE. NO

2101 Bolton

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White Widowed

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Widow of Wm. E. Fink

6 DATE OF BIRTH (month, day, and year)

Nov 28 / 1868

7 AGE

Years

Months

Days

or LESS than

1 day, hrs.

or min.

54 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

at home

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Wm. E. Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Delaware

12 MAIDEN NAME OF MOTHER

Emma Stewart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md

14

Informant

(Address)

Emma S. Johnson 2101 Bolton St

15

Filed Robert F. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 9 1912

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 7 - 1922, to Nov. 9 - 1922

that I last saw him alive on Nov 9 - 1922

and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

Probably one year or more (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Toemia & inanition about 3 months (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? operation 18 months ago for Carcinoma of Pancreas Date of operation

Was there an autopsy? Yes

What test confirmed diagnosis? Examined by Region & internist

(Signed) Carlton M. Cook, M. D.

1922 (Address) 1107 W. Sanborn St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Furnishing Pa Nov 11 1912

20 UNDERTAKER

ADDRESS

William Cook 502 E North St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

9-1922
Block 17022 Lantana St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 69075

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 69075

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4307 PENHURST AVE ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CAMERON MACRAE LAMB

(a) RESIDENCE. NO. 4307 Penhurst Ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced (write the word)

MALE WHITE Single

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) FEB. 25, 1920

 7 AGE Years Months Days If LESS than 1 day, hrs. or min.
 2 8 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) WILSON N.C. (State or country)

10 NAME OF FATHER JOHN C. LAMB

11 BIRTHPLACE OF FATHER (city or town) WILLIAMSTON N.C. (State or country)

12 MAIDEN NAME OF MOTHER FANNIE MACRAE

13 BIRTHPLACE OF MOTHER (city or town) FAYETTEVILLE N.C. (State or country)

14 Informant Jno. C. Lamb (Address) 4307 Penhurst Ave

15 NOV 10 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9th 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 18th 1922, to Nov 4th 1922,

that I last saw him alive on Nov. 8, 1922,

and that death occurred, on the date stated above, at 8:10 m.

The CAUSE OF DEATH* was as follows;

Lobular pneumonia, secondary to an eruptive disease previously reported as Rubella but probably measles (duration) yrs. mos. 22 ds.

CONTRIBUTORY Measles (Secondary)

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. H. Wagoner, M. D.

11.10.19 (Address) 1510 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge Cem

Nov 10 1922

20 UNDERTAKER

Henry H. Jenkins Snow

ADDRESS

McCullish Orchard

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Aisquith St. ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. H. Fisher(a) RESIDENCE No. 914 Aisquith St. ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower5a If married, widowed, or divorced HUSBAND of the late Mary. A. Fisher6 DATE OF BIRTH (month, day, and year) Sept. 27, 18477 AGE Years 75 Months 1 Days 11 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.10 NAME OF FATHER Joseph Fisher11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)12 MAIDEN NAME OF MOTHER Not known13 BIRTHPLACE OF MOTHER (city or town) Not known (State or country)14 Informant Mr. Harry. J. Fisher (Address) 914 Aisquith St.15 NOV 10 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 192217 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1921, to Nov 9, 1922,that I last saw him alive on Nov 7, 1922,and that death occurred, on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:

(duration) 1 yrs. 11 mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. 11 mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. R. Fisher, M. D., 1922 (Address) 836 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer Cemetery

DATE OF BURIAL

Nov. 17 1922

20 UNDERTAKER

ADDRESS

Harry Horst (son) 1391 E. Eager St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21-M&T-1500 Bks.

69077 HEALTH DEPARTMENT-CITY OF BALTIMORE 69077

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Anthony ST., 10 WARD)

2-FULL NAME Dorothy B. Schmitt

(a) RESIDENCE No. 1413 Anthony ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 29 1912

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 11

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Andrew J. Schmitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Dorothy Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mr. Andrew J. Schmitt (Address) 1413 Anthony St.

15 Filed NOV 10 1922 ROBERT R. KRAUTER Registrar

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident, give city or town and State)

16 DATE OF DEATH (month, day, and year) November 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 8 1922 to Nov 9 1922

that I last saw h alive on 19

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Heart Failure. Extremes.

7 1/2 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Encephalic Malformation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Meyer M. D.

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Holy Redeemer Cemetery DATE OF BURIAL November 19, 1922

20 UNDERTAKER Henry Horst Son ADDRESS 1361 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1354 N Carey* ST. *15* WARD)2-FULL NAME *Sewell Thayer*(a) RESIDENCE NO. *1354 N Carey*

(Usual place of abode)

Length of residence in city or town where death occurred *25* yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced. (write the word)

*Male**Colored**Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 18, 1871*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*51**4**7*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

*Janitor*9 BIRTHPLACE (city or town)
(State or country)10 NAME OF FATHER *John Thayer*11 BIRTHPLACE OF FATHER (city or town)
(State or country)12 MAIDEN NAME OF MOTHER *Ellen Richardson*13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

PARENTS

14

Informant
(Address)

15

Filed

19

ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 8* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 6, 19 *22*, to *Nov 8*, 19 *22*.that I last saw him alive on *Nov 8*, 19 *22*.and that death occurred, on the date stated above, at *11:45 A.* m.

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue

(duration)

yrs.

11 mos.

ds.

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?Did an operation precede death? *yes* Date of *Nov 10, 1922*Was there an autopsy? *no*

What test confirmed diagnosis?

Microscope. After
operation Spring 1922
(Signed) *William H. Wright* M. D.*Nov 9, 1924* (Address) *1209 Preston and*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVING

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Therapist Hill Cemetery
1354 N Carey

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

✓ 069079 1522
LTIMORE
31
39
1883

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Mary C Wade

8145-Demo 11

WARD

(If non-resident give city or town and State)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 9* 19 *72*

17 I HEREBY CERTIFY, That I attended deceased from
Oct 28, 1922 to Nov 8, 1922
that I last saw him alive on Nov 8, 1922

and that death occurred, on the date stated above, at 11:15 a.m.

The CAUSE OF DEATH* was as follows:

Removal of the lungs

... (duration) ... yrs. mos 13 ds.

CONTRIBUTORY (Secondary) *Immediate Cause*
Proximate Cause

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? W Date of _____

4. Was there an autopsy? (no)

What test confirmed diagnosis? _____

(Signed) L. A. McKeen M. D.

19. (Address) 1303 W. 10th St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL

MOVAL *[Signature]* DATE OF DEPARTURE *[Signature]*

Ab E. F. F. 19

20 UNDERTAKER	ADDRESS
---------------	---------

✓ *Handwritten signature*

Harold Lloyd Garrison

Handwritten musical notation on a five-line staff, showing a sequence of notes and rests.

state
 PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

69080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164001 69080

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2211 Grove

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

ST. 21 WARD

2-FULL NAME Veronik M Wolfe

(a) RESIDENCE. No. 2211 Grove

(Usual place of abode)

ST.

WARD. 25

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

F

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced (write the word)
Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.

Oct 31th

1922

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

J. Wolfe

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

M. Marmas

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Baltimore Md.

14

Informant

J. Wolfe

(Address)

2211 Grove Street

15

NOV 10 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct 31, 1922 to Nov. 10, 1922

that I last saw her alive on Nov. 9, 1922

and that death occurred, on the date stated above, at 5. A. m.

The CAUSE OF DEATH* was as follows:

Congenital debility

CONTRIBUTORY
(Secondary)

(duration)

yrs.

mos.

ds.

Premature birth wgt 3 pounds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

M. B. Frutiger

M. D.

11/10/22

Address 682 Washington Blvd -

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Holy Redeemer

Nov. 10. 1922

20 UNDERTAKER

ADDRESS

J. Grebliauckas

425 S Paca St

Play 1350

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

969081 HEALTH DEPARTMENT—CITY OF BALTIMORE 969081

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1121 E. Balto. St. 5 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1121 E. Balto. St.; yrs. 22 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. White 5-Single, Married, Widowed, or Divorced. Single (Write the word.)

6-DATE OF BIRTH. Unknown 1. (Month) (Day) (Year)

7-AGE. 22 about If LESS than 1 day, yrs. mos. ds. hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Salesman (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Chicago

10-NAME OF FATHER. Harry Levey

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Sarah Shapiro

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Levey

(Address) 2424 Woodbrook Ave

15. NOV 10 1922 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 10 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest, autopsy or inquiry, thereon and from the evidence obtained by said Inquest, an topsy or inquiry, find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Signed) J. B. Norton M. D. (Coroner) Nov 10 1922 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury, and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Helms Haring Piers 11/16 1922

20-UNDERTAKER, ADDRESS 1127 E

L. Quinon Balto St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

269082

HEALTH DEPARTMENT—CITY OF BALTIMORE

269082

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1534 N. Washington St.
CITY OF BALTIMORE: (No. 1534 N. Washington St., 8 WARD)
2-FULL NAME William W. Bollinhofer
(a) RESIDENCE NO. 1534 N. Washington St., 8 WARD
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Bollinhofer

6 DATE OF BIRTH (month, day, and year) Mar 28 1885

7 AGE Years 35 Months 7 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Gov. Automobiles
(c) Name of employer U. S. Government

9 BIRTHPLACE (city or town) Baltimore City (State or country)

10 NAME OF FATHER Wm G. Bollinhofer

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Kate King

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Margaret Bollinhofer (Address) 1534 N. Washington St.

15 NOV 10 1922 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 4, 1922, to Nov 8, 1922, that I last saw him alive on Nov 8, 1922, and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) yrs. 6 mos. ds.

18 Where was disease contracted? In U. S. Army if not at place of death? Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Usual tests (Signed) C. E. McDonald, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

20 UNDERTAKER

Philip Herwig

DATE OF BURIAL

11/10 1922

ADDRESS 2016

Albany

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

69083

HEALTH DEPARTMENT—CITY OF BALTIMORE

69083

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 108 1/2 Franklin St. 18 Ward)

Registered No. C.....

2-FULL NAME *David E. Hopkins*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 108 1/2 Franklin St., yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *white* 5-Single, Married, Widowed, or Divorced, *married* (Write the word.)

6-DATE OF BIRTH, *Oct 9* 1887 (Month) (Day) (Year)

7-AGE, *65* yrs., mos., ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Bookkeeper* (b) General nature of industry, business, or establishment in which employed (or employer), *008*

9-BIRTHPLACE, (State or Country), *England*

10-NAME OF FATHER, *Don't know*

11-BIRTHPLACE OF FATHER, (State or Country), *England*

12-MAIDEN NAME OF MOTHER, *Mary Harpur*

13-BIRTHPLACE OF MOTHER, (State or Country), *Ireland*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Susan Hopkins*

(Address) *1301 Howard Ave*

15. NOV 10 1922 ROBERT R. KRAUTER,

Filed 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Oct 9* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: *Valvular Disease of the Heart*

CONTRIBUTORY (Secondary) *Don't know*

(Signed) *H. H. Gorman* M. D. (Coroner.) 11-10-1922 (Address) *117 1/2 Jackson St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Baltimore Cemetery* DATE OF BURIAL, *Nov 13* 1922

20-UNDERTAKER, *Robt & Finner Inc 4 Broadway* ADDRESS *1442*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 M&T 1560 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 Guilford Ave. ST. 12 WARD)

2-FULL NAME Thomas E. Perry

(a) RESIDENCE NO. 2321 Guilford Ave. ST. 12 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nina Perry

6 DATE OF BIRTH (month, day, and year) Mar. 28 1865

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
57 7 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer on

(b) General nature of industry, business, or establishment in which employed (or employer) Lannon

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER William Perry

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Evans

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. Nina Perry
(Address) 2321 Guilford Ave.

15 Filed NOV 10 1922 ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 24, 1922, to Nov. 8, 1922.

that I last saw him alive on Nov. 8, 1922.

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Oedema of the lungs

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry J. Boyd, M. D.

2-15-22 (Address) 624 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Olivet Cem

DATE OF BURIAL

11/11 1922

20 UNDERTAKER

J. Faw M. Conly

ADDRESS

130 E. Fort

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Chr. Interstitial Nephritis

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Revised 1-10-21 M&T 1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3803 Kate Ave.

ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Joseph P. Hamper Jr.

(a) RESIDENCE NO.

3803 Kate Ave.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7th 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

Md.

10 NAME OF FATHER Joseph P. Hamper

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

Md.

12 MAIDEN NAME OF MOTHER Laura B. Insley

11/9/22 (Address) 14 E. Read St.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bivalve

Md.

14

Informant Joseph P. Hamper (Address) 3803 Kate Ave.

15

Filed

19

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9th 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov. 7th 19 22 to Nov. 9th 19 22.

that I last saw him alive on Nov. 9th 19 22.

and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Injuries at birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Thos. H. Mayne, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Bivalve, Md.

Nov. 10th 19 22

20 UNDERTAKER

ADDRESS

Joseph B. Cook

1003 N. Baltimore St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *100 N. Bazaar St. 14* Ward)

Registered No. *69086*

2-FULL NAME

(Residence in Baltimore: No. *1425 Linden av* St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married*
(Write the word.)

6-DATE OF BIRTH, *Dec 15 1869*
December (Month) 15th (Day) 1869 (Year)

7-AGE, *52* yrs. *10* mos. *24* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *Cash taker at 1080 Bay View Park*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Balt Md*

10-NAME OF FATHER, *J M Chambers*

11-BIRTHPLACE OF FATHER, (State or Country), *Balt Co*

12-MAIDEN NAME OF MOTHER, *Rosa Dryden*

13-BIRTHPLACE OF MOTHER, (State or Country), *Balt Co Md*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs Mary Chambers*

(Address) *1425 Linden Ave.*

15-

Filed *NOV 10 1922* 1922 *ROBERT R. KRAUTER,* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 8 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* and that said deceased came to *his* death *by* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal disease of the Heart

(Duration) *Don't know* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Don't know*

(Signed) *J. H. General* M. D. (Coroner.)

Nov 11 1922 (Address) *1127 N. Dardar*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *St. Christ Church* DATE OF BURIAL, *Nov 11 1922*

20-UNDERTAKER, *Joseph B. Cook* ADDRESS, *1003 N. Baltimore*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

I-PLACE OF DEATH CITY OF BALTIMORE: (No. <u>6265 Bradford</u> ST. <u>1</u> WARD)		REGISTERED NO. <u>113</u> <u>69087</u> (If death occurred in a hospital or institution, give its NAME instead of street and number.)	
2-FULL NAME <u>Mary Hildeman</u>			
(a) RESIDENCE NO. <u>6265 Bradford</u> (Usual place of abode)		ST. <u>1</u> WARD <u>1</u> (If non-resident give city or town and State)	
Length of residence in city or town where death occurred <u>2</u> yrs. <u>4</u> mos. <u>4</u> ds.		How long in U. S., if of foreign birth? yrs. mos. ds.	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 Single, Married, Widowed, or Divorced, (write the word) <u>Single</u>	
5a If married, widowed, or divorced HUSBAND of (or) WIFE of <u>—</u>			
6 DATE OF BIRTH (month, day, and year) <u>Dec 9/1910</u>			
7 AGE	Years <u>1</u>	Months <u>11</u>	Days <u>—</u> If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <u>—</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u> (c) Name of employer <u>—</u>			
9 BIRTHPLACE (city or town) (State or country) <u>Ind.</u>			
10 NAME OF FATHER <u>W Hildeman</u>			
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>Ind.</u>			
12 MAIDEN NAME OF MOTHER <u>M Hastley</u>			
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Ind.</u>			
14 Informant <u>M. Hildeman</u> (Address) <u>626 Bradford St</u>			
15 Filed <u>NOV 10 1922</u> Bureau of Vital Statistics Registrar <u>ROBERT R. KRAUTER</u>			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH (month, day, and year) <u>Nov 7</u> 19 <u>22</u>			
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 1</u> , 19 <u>22</u> to <u>Nov 7</u> , 19 <u>22</u> that I last saw him alive on <u>Nov 7</u> , 19 <u>22</u> and that death occurred, on the date stated above, at <u>1</u> m. The CAUSE OF DEATH* was as follows: <u>Auto auto auto</u> (duration) yrs. mos. <u>8</u> ds.			
CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.			
18 Where was disease contracted if not at place of death? <u>—</u>			
Did an operation precede death? <u>—</u> Date of <u>—</u>			
Was there an autopsy? <u>—</u>			
What test confirmed diagnosis? <u>—</u>			
(Signed) <u>—</u> M. D. , 19 <u>22</u> (Address) <u>—</u>			
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)			
19 PLACE OF BURIAL, CREMATION OR RE-MOVAL <u>Mount Carmel Cemetery</u>		DATE OF BURIAL <u>Nov 10 1922</u>	
20 UNDERTAKER <u>George J. Ruth</u>		ADDRESS <u>1735 Hayford Ave</u>	

PHYSICIANS should state
Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST., _____ WARD)

2-FULL NAME

(a) RESIDENCE No. _____ ST., _____ WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 6 ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 27 1899

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 3 1922 to Nov 9 1922 that I last saw her alive on Nov 9 1922 and that death occurred, on the date stated above, at 9:30 A.M. The CAUSE OF DEATH* was as follows:

Retained placenta Hemorrhage.

(duration) 8 hours yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 9, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. H. M. M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery Nov 13 1922

20 UNDERTAKER

ADDRESS

George F. Ruth 1735 Hayford Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2110 Druid Hill Ave* ST.: *14* WARD)2-FULL NAME *John Terrell Jones*(a) RESIDENCE. No. *2110 Druid Hill Ave* ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *Life* mos.

ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *M*4 COLOR OR RACE *C*5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 6, 1922*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *2 3*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *md*10 NAME OF FATHER *Warner C Jones*11 BIRTHPLACE OF FATHER (city or town) (State or country) *md*12 MAIDEN NAME OF MOTHER *Thelma M. Hall*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *md*

PARENTS

14 Informant *Thelma M. Jones* (Address) *2110 Druid Hill Ave*

15

Filed

, 19

Registrar

NOV 10 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 9* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 1*, 19*22*, to *Nov 9*, 19*22*.that I last saw him alive on *Nov 9*, 19*22*.and that death occurred, on the date stated above, at *9 A* m.

The CAUSE OF DEATH* was as follows:

Prima maturity

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *Indigestion*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*

What test confirmed diagnosis?

(Signed) *H. S. McCard* M. D. *11/9, 1922* (Address) *2005 Druid Hill Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

New Cathedral Cemetery

20 UNDERTAKER

Jno. M. Johnson

DATE OF BURIAL

Nov. 10 19*22*ADDRESS *1234**Etting St.*

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Gastrointestinal

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69090		HEALTH DEPARTMENT—CITY OF BALTIMORE		D69090	
1-PLACE OF DEATH				CERTIFICATE OF DEATH.	
City of BALTIMORE: (No. <i>3700 E. Lombard St.</i> Ward <i>16</i>)		Registered No. C.....		(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)	
2-FULL NAME <i>August K. Klingenberg</i>		(Residence in Baltimore: No. <i>3700 E. Lombard St.</i> yrs. mos. ds.)			
PERSONAL AND STATISTICAL PARTICULARS.				CORONER'S CERTIFICATE OF DEATH.	
3-SEX <i>Male</i>	4-COLOR OR RACE <i>White</i>	5-Single, Married, Widowed, or Divorced. <i>Widowed</i>	16-DATE OF DEATH, <i>Nov. 9</i> , 192 <i>2</i> (Month) (Day) (Year)		
6-DATE OF BIRTH, <i>March 20</i> , 184 <i>9</i> (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>Inquiry</i> thereon and from the evidence obtained by said <i>Inquiry</i> and that said deceased came to <i>this</i> death topsy or Inquiry.) on the day stated above.		
7-AGE <i>73</i> yrs. <i>7</i> mos. <i>20</i> ds. If LESS than 1 day, hrs. or min.?			The CAUSE OF DEATH* was as follows: <i>Fractured Skull</i> <i>and when found</i> <i>Fell down stairs steps</i>		
8-OCCUPATION: (a) Trade, profession, or particular kind of work <i>Carpenter</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>015</i>			CONTRIBUTORY (Secondary) <i>Nov 10 1922</i>		
9-BIRTHPLACE, (State or Country), <i>Balto-Md</i>			(Signature) <i>Thos B. Norton</i> M. D. <i>Nov 10 1922</i> (Address) <i>Curtis Bay</i>		
PARENTS.	10-NAME OF FATHER <i>Louis Klingenberg</i>		*State the Disease Causing Death, or in case of violent Causes, state (1) Means of Injury; (2) Whether Accidental, Suicidal, or Homicidal.		
	11-BIRTHPLACE OF FATHER, (State or Country), <i>Germany</i>		18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds.		
	12-MAIDEN NAME OF MOTHER <i>Hendricka Newell</i>		Where was disease contracted, if not at place of death?		
	13-BIRTHPLACE OF MOTHER, (State or Country), <i>Germany</i>		Former or usual residence.....		
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Mrs. Alice Schaefer</i> (Address) <i>236 N. Milton Ave</i>			19-PLACE OF BURIAL, OR REMOVAL, <i>Western Cem</i> DATE OF BURIAL, <i>Nov. 11</i> , 192 <i>2</i>		
15- Filed <i>NOV 10 1922</i> ROBERT R. KRAUTER Registrar.			20-UNDERTAKER, <i>Jos. J. Herr</i> ADDRESS <i>156 W. Luzerne</i>		

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 742 W. Fayette ST., WARD 27)2. FULL NAME Wilhemine Root(a) RESIDENCE NO. Evergreen ave. near Overka Ave. Overka

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Widowed5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Root6 DATE OF BIRTH (month, day, and year) June 13th 1835

7 AGE

Years 87Months 5Days 4

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

PARENTS

14 Informant (Address) W. C. F. Root 742 W. Fayette St.

15

NOV 10 1922

ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 8, 19 22, to Nov. 9, 19 22that I last saw him alive on Nov. 8, 19 22and that death occurred, on the date stated above, at 2400 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage(duration) yrs. mos. ds. 1

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry G. Shuman, M. D.19.7.19 (Address) 2688

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

NOVAL
Parkwood Cemetery Nov 11 1922

20 UNDERTAKER

ADDRESS

Fred. Lessum Sons Fullerton

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

069092

HEALTH DEPARTMENT—CITY OF BALTIMORE

069092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 N. Fremont Ave. St. 16 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew H. Hefner

(Residence in Baltimore: No. 1318 N. Fremont Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, 4-COLOR OR RACE, 5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, 7-AGE, If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work, (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), 10-NAME OF FATHER, 11-BIRTHPLACE OF FATHER, (State or Country), 12-MAIDEN NAME OF MOTHER, 13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Hefner, (Address) 1318 N. Fremont Ave.

15-NOV 10 1922

ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to this death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute pneumonia

(Duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D., (Coroner.)

Nov. 10, 1922 (Address) 2522 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Cathedral Ave Nov. 11, 1922

20-UNDERTAKER, ADDRESS

Martin Kakey & Son, 1527 W. North Ave.

D69093

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69093

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 5008 Beaufort Ave. ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Martha Kahn

(a) RESIDENCE. NO.

206 Augusta Ave.

WARD.

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Wht

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar. 9-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

1 hr

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

Edward Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Marie E. Schmitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto. Md

14

Informant (Address)

Edward Kahn 206 Augusta Ave

15

Filed

NOV 10 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 9 1922

17

I HEREBY CERTIFY, That I attended deceased from Mar. 9 1922, to Mar 9 1922,

that I last saw her alive on Mar 9 1922,

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Cranial injury

(duration) 0 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

atelectasis

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Macdonald, M. D.

, 19 (Address) 821 N. Pratt St. av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Western Cemetery Mar. 10 1922

20 UNDERTAKER

ADDRESS

George L. Schmitt 401 E. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 6-9-19 H. P. Co. 1000 Rks.

969094

HEALTH DEPARTMENT—CITY OF BALTIMORE

969094

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. East A)

ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Emilyn E. Leicht

(a) RESIDENCE. NO.

19 S. East A

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 8, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto, Ind.

10 NAME OF FATHER

Arthur Leicht

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto, Ind.

12 MAIDEN NAME OF MOTHER

Emma Leicht

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto, Ind.

14

Informant (Address)

Arthur Leicht
19 East Ave.

15

Filed

19

ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 8 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 2, 1922, to Nov. 8, 1922.

that I last saw her alive on Nov. 2, 1922.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis.

(duration) Yrs. Mos. 14 Ds.

CONTRIBUTORY (Secondary)

(duration) Yrs. Mos. Ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. L. Hoff, M. D.

, 19 (Address) 1243 W. Balto St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL DATE OF BURIAL

St. John's Trinity Cemetery, Nov. 10, 1922

20 UNDERTAKER

ADDRESS

George L. Schrab 2101 Bude Ave.

10.69095 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.69095

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 E. Randall ST., WARD 23)

2-FULL NAME

(a) RESIDENCE NO. 39 E. Randall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

1 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

File

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1922, to Sept. 1922, that I last saw her alive on Nov 7, 1922,

and that death occurred, on the date stated above, at 4:30 pm.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

duration

yrs. 6 mos. ds.

duration

yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed)

J. H. H. M. D.

K/C 1924 (Address)

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

101922

Daniel Peratt Clerk

Margaret G. Flynn

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 W Lombard ST.; 19 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of Ezra Rosenstock & Carrie E. Weaver(Residence in Baltimore: No. 1519 W Lombard St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE,

White5-SINGLE, single
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

6-DATE OF BIRTH,

Nov 10, 1922
(Month) (Day) (Year)

7-AGE,

yrs. mos. ds.

If LESS than 1 day,

...hrs. or 15 min.?

8-OCCUPATION:

(a) Trade, profession, or particular

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE,
(State or Country),Baltimore Md

10-NAME OF FATHER,

Ezra Rosenstock11-BIRTHPLACE OF FATHER
(State or Country),Maryland

12-MAIDEN NAME OF MOTHER

Carrie E. Weaver13-BIRTHPLACE OF MOTHER
(State or Country),Hanover Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie E. Weaver(Address) 1519 W Lombard St

15-

Robert P. Harrison,JOHNS HOPKINS HOSPITAL

Filed

191

Burial Permit Clerk, Registrar.19647

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov 10, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov 10 1922, to Nov 10 1922,that I saw her alive on Nov 10 1922,and that death occurred, on the date stated above, at 6¹⁵ a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY Birth
(Secondary)

(Duration) yrs. mos. ds.

(Signed) J. E. Harrison M. D.Nov 10, 1922 (Address) 1520 Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

....., 191...

20-UNDERTAKER

ADDRESS

Commissioner Health,

Per. Wm E. WOODBALL

Nov 10 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(Bonhage)
10.69097 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.69097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. on Race St. or Lexington St. 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Phil Bonhage

(Residence in Baltimore: No. 535 or Fremont St. 40 St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE. white 5-Single, Married, Widowed, or Divorced. Married (Write the word.)

6-DATE OF BIRTH. Sept 12, 1893 (Month) (Day) (Year)

7-AGE. 79 yrs. 1 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. none (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

10-NAME OF FATHER. Don't know

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Don't know

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elj. Bonhage

(Address) 535 N. Fremont

15 Robert P. Harrison,

Filed 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 8, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by auto. Cause of death shock (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Struck by auto. a few minutes (Duration) yrs. mos. ds. (Signed) W. J. Gessner M. D. (Coroner.)

11-9-1922 (Address) 117 N. Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem. DATE OF BURIAL, Nov 11, 1922

20-UNDERTAKER, Mrs. John W. Timpfson ADDRESS 801 W. Fayette St.

dl. 69098

HEALTH DEPARTMENT—CITY OF BALTIMORE

dl. 69098

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

650 N. Franklin ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Sarah Q. Roberts

(a) RESIDENCE. No.

650 N. Franklin ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Widow

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Samuel Roberts

6 DATE OF BIRTH (month, day, and year)

July 17, 1850

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

72

3

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Bath Md.

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Bath Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Bath Md.

14

Informant
(Address)William R. Roberts
516 Union Ave.

15

Name

Robert P. Harrison

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 8 1922

I HEREBY CERTIFY, that I attended deceased from Nov. 10, 1921, to Nov. 8, 1922,

that I last saw him alive on Nov. 8, 1922,

and that death occurred, on the date stated above, at 1.20 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

CONTRIBUTORY
(Secondary)

Artero-Sclerosis

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H. Magnus M. D.

11/8/1922 Address 14. East Road St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

London Park

DATE OF BURIAL

Nov 11 1922

20 UNDERTAKER

H. M. Cook 502 E. North Ave.

ADDRESS

10.69099 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.69099

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Elliott(a) RESIDENCE NO. Franktown, Va. ST. 7 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 days mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 17 - 19057 AGE Years 17 Months 7 Days 21 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va. (State or country)10 NAME OF FATHER John D. Elliott11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)12 MAIDEN NAME OF MOTHER W. Nottingham13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14

Informant JOHNS HOPKINS HOSPITAL (Address)

15

Filed Robert P. Harrison, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 30 1922 to Nov 10 1922,that I last saw him alive on Nov 10 1922,and that death occurred, on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

(Hypophyseal duct tumor)
Brain tumor(duration) 2 yrs mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? Va.Did an operation precede death? Yes Date of Nov 8 22Was there an autopsy? YesWhat test confirmed diagnosis? operation(Signed) F. H. Reichert M. D.19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Exmore, Northampton County Va. Nov 11 1922

20 UNDERTAKER

ADDRESS

Wm. Cook502 E North

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

20.69100

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.69100

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1406 Laurens ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

James Walter Jackson

(a) RESIDENCE NO.

1406 Laurens

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced, (write the word)

Single (chd)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar 22/22

7 AGE

Years

Months

Da

If LESS than
1 day, hrs.
or min.

7

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balt
Md

10 NAME OF FATHER

David Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balt
Md

12 MAIDEN NAME OF MOTHER

Martha Cooper

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balt
Md

14

Informant
(Address)Martha Cooper
1406 Laurens St

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1 1922 to Nov 9 1922

that I last saw him alive on Nov. 9, 1922

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Pneumonia)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

11/9/22 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVING

Mt Auburn

DATE OF BURIAL

20 UNDERTAKER

Daniel Easton

ADDRESS

11/11/22

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

dl. 69101 HEALTH DEPARTMENT—CITY OF BALTIMORE dl. 69101

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No 719 W. Mulberry ST. WARD

2-FULL NAME

Hennetta Howell

(a) RESIDENCE. No

719 W Mulberry

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Howell

6 DATE OF BIRTH (month, day, and year) Unknown 1852

7 AGE Years 70 Months - Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer at home

9 BIRTHPLACE (city or town) Berlin (State or country) Md

10 NAME OF FATHER John Carey

11 BIRTHPLACE OF FATHER (city or town) Berlin (State or country) Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Berlin (State or country) Md

14 Informant Daniel Easton (Address) 914 Pennell Ave

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 7 1922, to Nov 9 1922, that I last saw her alive on Nov 9 1922, and that death occurred, on the date stated above, at 11:45 a.m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John R. Carey, M. D.

, 19 (Address) 7521 George St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Daniel Easton Nov 12 1922

20 UNDERTAKER ADDRESS

Daniel Easton Pa

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

22.69102

HEALTH DEPARTMENT—CITY OF BALTIMORE

22.69102

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1617 Repton Cr. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME May Eleanor Chenoweth

(Residence in Baltimore: No. 1617 Repton Cr. St. 6 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-MARRIED Widowed

6-DATE OF BIRTH Sept 18, 1858

7-AGE 64 yrs. 1 mos. 21 ds. or min.?

8-OCCUPATION (a) Trade, profession or particular kind of work nothing (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER James M Love

11-BIRTHPLACE OF FATHER (State or country) Maryland

12-MAIDEN NAME OF MOTHER Ruth Coulson

13-BIRTHPLACE OF MOTHER (State or country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Russell Chenoweth

(Address) 2020 Grayson Cr

MEDICAL CERTIFICATE OF DEATH

10-DATE OF DEATH 11 9, 1922

17- I HEREBY CERTIFY, That I attended deceased from 1917, to, 11/9, 1922, that I saw her alive on 11/9, 1922, and that death occurred, on the date stated above, at 4.9 a.m.

The CAUSE OF DEATH* was as follows:

Paralysis of deglutition

(Duration) 5 yrs. mos. ds.

Contributory (SECONDARY) Arterio-sclerosis

(Duration) several yrs. mos. ds.

(Signed) Henry Russell M. D. (Address) 3902 Grosvenor

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death... yrs... mos... ds. In the State... yrs... mos... ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

London Park Nov 11, 1922

20-UNDERTAKER ADDRESS

Isiah Sykes 1600 N. North Ave

16- Robert P. Harrison,

1922 Burial Permit Clerk.

REGISTRAR

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.69104 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.69104

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Ward 10 Hospital 71* Registered No. C.....
City of BALTIMORE (No. *6* St. *178* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Catherine Newton*
(Residence in Baltimore: No. *1105 Columbia Ave* St. *17* yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Female</i>	4-COLOR OR RACE <i>White</i>	5-Single, Married, Widowed, or Divorced. (Write the word.) <i>Single</i>
6-DATE OF BIRTH <i>Sept 25 1905</i> (Month) (Day) (Year)		
7-AGE <i>17</i> yrs. mos. ds.		If LESS than 1 day. hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer). <i>School Girl</i>		
9-BIRTHPLACE. (State or Country). <i>Balto md</i>		
PARENTS.	10-NAME OF FATHER. <i>Paul F Newton</i>	
	11-BIRTHPLACE OF FATHER. (State or Country). <i>Balto md</i>	
	12-MAIDEN NAME OF MOTHER. <i>Zula Huttelberger</i>	
	13-BIRTHPLACE OF MOTHER. (State or Country). <i>Balto md</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Zula Huttelberger*
(Address) *1105 Columbia Ave*

15-
Robert P. Harrison,
1922
Bureau Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Nov-11-22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.
I hereon and from the evidence obtained by said Inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:
Accidental
Fumes, 3rd Floor
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) *Boys*
(Signed) *E. O. C. Butler* M. D.
(Address) *1011 1/2 14th St. Baltimore*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
St. Margaret's *Nov 12 1922*

20-UNDERTAKER. ADDRESS
John J. Fields *1200 N. Lombard*

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

20.69105 HEALTH DEPARTMENT—CITY OF BALTIMORE 20.69105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. *Johns Hopkins Hosp 15* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Virginia Elizabeth Jones*
(Residence in Baltimore: No. *3412 Elgin Ave* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <i>Female</i>	4-COLOR OR RACE. <i>White</i>	5-Single, Married, Widowed, or Divorced. (Write the word.)
6-DATE OF BIRTH. <i>Aug 16</i> 1922 (Month) (Day) (Year)		
7-AGE. <i>2</i> yrs. <i>7</i> mos. <i>25</i> ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)		
9-BIRTHPLACE. (State or Country), <i>Balt Md</i>		
PARENTS.	10-NAME OF FATHER. <i>Robert L. Jones</i>	
	11-BIRTHPLACE OF FATHER. (State or Country), <i>Balt Md</i>	
	12-MAIDEN NAME OF MOTHER. <i>Mary Macken</i>	
	13-BIRTHPLACE OF MOTHER. (State or Country), <i>Balt Md</i>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) *Robert L. Jones*
(Address) *3412 Elgin Ave*

15-
Filed *Robert P. Harrison,* 1922
Registrar. *Burial Permit Clerk.*

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 10* 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.
The CAUSE OF DEATH* was as follows:
Intussusception
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Signed) *J. H. Potter* M. D. (Coroner.)
11-11 1922 (Address) *508 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. *Greenmount* DATE OF BURIAL. *Nov 11* 1922

20-UNDERTAKER. *H. E. Hughes* ADDRESS *424 N. Broadway*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert F. Harrington,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 7, 1922, to Nov 10, 1922,

that I last saw him alive on Nov 9, 1922,

and that death occurred, on the date stated above, at 7:15 A. M.

The CAUSE OF DEATH* was as follows:

Heart exhaustion

(duration) X yrs. X mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) X yrs. 1 mos. X ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Same

Signed J. L. Thomas, M. D.

19 (Address) 248 So 3d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Sacred Heart Am.

DATE OF BURIAL

Nov. 11 1922

20 UNDERTAKER

Lilly & Zeiler

ADDRESS

403 S. Myrtle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE **20.69107**
20.69107

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

Howard G. Kelly Hospital

WARD)

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

2-FULL NAME

Mr. Albert Randolph

(a) RESIDENCE. NO.

New Milton W. Va.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

Z

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Lucy E. Randolph

6 DATE OF BIRTH (month, day, and year)

June 16 1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

65

3

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Farmer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)New Milton
West Va

10 NAME OF FATHER

Jephtha F. Randolph

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Salem
West Va

12 MAIDEN NAME OF MOTHER

Deborah Sutton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Salem
West Va

14

Informant
(Address)Mrs Jessie McElain
Blandville W. Va

15

Filed

ROBERT F. HARRISON,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 10th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 9th 1922 to Nov. 10th 1922that I last saw him alive on Nov. 10th 1922

and that death occurred, on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH was as follows:

Acute Cholecystitis

CONTRIBUTORY

(Secondary)

abscess from rupture

(duration)

yrs.

mos.

10

ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Nov 10, 1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

New Milton W. Va

Nov 11 1922

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

11 1922

Burial Permit Clerk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. _____ ST., _____ WARD)

2-FULL NAME

(a) RESIDENCE No. _____ ST., _____ WARD

(Usual place of abode)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds.

How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced

HUSBAND of _____
(or) WIFE of _____

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country)

14

Informant _____
(Address)

15

Filed _____, 19 _____

Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 8 - 1922, to Nov 9, 1922

that I last saw him alive on Nov 9, 1922

and that death occurred, on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH* was as follows:

Brain tumor - rt. cerebral glioma
(Possible vascular affair)

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death? Home

Did an operation precede death? Yes Date of Nov 8 '22

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) F. L. Reichert, M. D.

, 19 _____ (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

11/1922

Partial Permitt Clock

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2836 W. Lanvale ST. 16 WARD)

2-FULL NAME

(Residence in Baltimore: No. 2836 W Lanvale St.; 65 yrs., 10 mos., 6 ds.)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

male

4-COLOR OR RACE,

white

5-SINGLE,

married
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan 3, 1857
(Month) (Day) (Year)

7-AGE,

65 yrs., 10 mos., 6 ds.

If LESS than 1 day,

...hrs. or...min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

mechanic
186

9-BIRTHPLACE,

(State or Country),

Balt. Md.

10-NAME OF FATHER,

Samuel Merriken

11-BIRTHPLACE OF FATHER

(State or Country),

Balt. Md.

12-MAIDEN NAME OF MOTHER

Caranda Braughton

13-BIRTHPLACE OF MOTHER

(State or Country),

Balt. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Merriken(Address) 2836 W. Lanvale

15-

Filed Robert B. Harrison, 19111922

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

November 9, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Oct-1 1922, to Nov 9 1922,that I saw him alive on Nov 8 1922,and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver(Duration) 2 yrs., 10 mos., 6 ds.

CONTRIBUTORY

(Secondary)

(Duration) 2 yrs., 10 mos., 6 ds.(Signed) E. Gill Hall M. D.Nov 10, 1922 (Address) 16178 North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

London Park Cemetery

DATE OF BURIAL,

Nov. 13, 1922

20-UNDERTAKER

W. M. Routson

ADDRESS

2238 14
North Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 S. Bouldin ST., No WARD)

2-FULL NAME

Albert S. Jones

(a) RESIDENCE NO.

926 S. Bouldin

ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of

(see with) Anna F. Jones.6 DATE OF BIRTH (month, day, and year) Oct 24, 1871

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

51-16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Wood-Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Tenn.

10 NAME OF FATHER

George Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Wales

12 MAIDEN NAME OF MOTHER

Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14

Informant (Address)

Anna F. Jones. 926 S. Bouldin St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 9 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 27, 1922, to Nov. 9, 1922.that I last saw him alive on Nov 8th, 1922and that death occurred, on the date stated above, at 4:25 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
neurorrhagic(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Sputum
(Signed) W. Jones, M. D.11/9, 1922 (Address) 1011 S. Ellwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Mt. Carmel Cemetery

20 UNDERTAKER

Finkler & Finkler

DATE OF BURIAL

Nov 12, 1922

ADDRESS

1739 Eager

Physician should state EXACTLY. Exact statement of OCCASION. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 69111 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 69111

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1551 Argyle Ave. St. 14th Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aleather Jackson

(Residence in Baltimore: No. 1551 Argyle Ave. St.; yrs., 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.			CORONER'S CERTIFICATE OF DEATH.	
3-SEX, female	4-COLOR OR RACE, colored	5-Single, Married, Widowed, or Divorced, (Write the word.) Married	16-DATE OF DEATH, Nov. 10, 1922 (Month) (Day) (Year)	
6-DATE OF BIRTH, about 1.864 (Month) (Day) (Year)			17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry, find that said deceased came to death on the day stated above.	
7-AGE, 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?			The CAUSE OF DEATH* was as follows: cerebral hemorrhage	
8-OCCUPATION: (a) Trade, profession, or particular kind of work, Cook			(Duration) yrs. mos. ds.	
9-BIRTHPLACE, (State or Country), Calvert Co. Md.			CONTRIBUTORY (Secondary) no history	
PARENTS.	10-NAME OF FATHER, Daniel Wilson		(Duration) yrs. mos. ds.	
	11-BIRTHPLACE OF FATHER, (State or Country), Md.		(Signed) J. T. Hennessey, M. D. (Coroner.)	
	12-MAIDEN NAME OF MOTHER, Davis/Kennedy		1922 (Address) 288 E. Lombard St.	
	13-BIRTHPLACE OF MOTHER, (State or Country), Md.		*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) Hannah Brown (Address) No. 8, W. 132 nd St. N.Y.C.				
15- Robert P. Harrison, Filed 1922 Burial Permit Clerk, Registrar.			18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence.	
19-PLACE OF BURIAL OR REMOVAL, Parkers Creek			DATE OF BURIAL, Nov 13, 1922	
20-UNDERTAKER, Calvert Co. Md.			ADDRESS 142	
John H. Loaders			4 Hill St	

10.69112 HEALTH DEPARTMENT—CITY OF BALTIMORE 10.69112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 S. Wolfe ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Smith

(a) RESIDENCE NO. 412 S. Wolfe
(Usual place of abode)

ST., 2 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10th 1922

7 AGE Years Months Days If LESS than 1 day 6 hrs. or 6 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

10 NAME OF FATHER Thomas Smith

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mamie Krugewiese

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Thomas Smith
(Address) 412 S. Wolfe St.

15 Filed Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1922, to Nov 10, 1922, that I last saw him alive on Nov 10, 1922,

and that death occurred, on the date stated above, at 10:10 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia
about 1/2 month duration
(duration) yrs. mos. ds.

CONTRIBUTORY Unknown - Cold
(Secondary) attending emergency
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John L. Vahner, M. D.
1922 (Address) 14 S. Murphy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Stanislaus Cem Nov 11, 1922

20 UNDERTAKER ADDRESS

Lilly & Ziller 400 S. Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Burial Permit Clerk

10.69113 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* Ward)

Registered No. C.....

2-FULL NAME. *Agnes Stokes*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. *1834 E. Eager*

St.; yrs., *7* mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE, *Colored*

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, *Sept* (Month) *27* (Day) *1912* (Year)

7-AGE, *1* yrs. *14* mos. *14* ds.

If LESS than 1 day,hrs. ormin.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *None*

(b) General nature of industry, business, or establishment in which employed (or employer). *None*

9-BIRTHPLACE, (State or Country). *Balets*

10-NAME OF FATHER, *James Stokes*

11-BIRTHPLACE OF FATHER, (State or Country), *Med*

12-MAIDEN NAME OF MOTHER, *Agnes Stokes*

13-BIRTHPLACE OF MOTHER, (State or Country), *Med*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Agnes Stokes*

(Address) *1834 E. Eager St.*

15-

Filed *11/11/22*

Robert F. Harrison,

192

Agnes Stokes

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov* (Month) *7* (Day) *1922* (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* find that said deceased came to *death* (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition

Autopsy at Hospital (Duration) *1* yrs. *1* mos. *14* ds.

CONTRIBUTORY (Secondary)

(Duration) *1* yrs. *1* mos. *14* ds.

(Signed) *W. H. Allen* M. D. (Coroner.)

11-10 1922 (Address) *505 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, *1* yrs. *1* mos. *14* ds. In the State, *1* yrs. *1* mos. *14* ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Laurel Cemetery *November 11, 1922*

20-UNDERTAKER, ADDRESS *1725-*

Mr Robert A Elliot Ashland St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Tuberculosis Hospital ST. 18 WARD)2-FULL NAME George Ford(a) RESIDENCE NO. 855 W. Franklin St. ST. 18 WARD
(Usual place of abode)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 19007 AGE Years 22 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer(b) General nature of industry, business, or establishment in which employed (or employer) Unknown(c) Name of employer Unknown9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER John F. Ford11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Florence Jones13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Hospital Records
(Address) M. E. Jones15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 192217 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1922, to Nov. 10, 1922.that I last saw him alive on Nov. 10, 1922.and that death occurred, on the date stated above, at 2.50 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? UnknownDid an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum(Signed) Francis L. Indeglia M. D.(Address) 11-10-22 Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Secret Heart

DATE OF BURIAL

Nov 11 1922

20 UNDERTAKER

Mr. Mrs. S. G. Girdle ADDRESS 1737 1/2 Pratt &

Physicians should state EXACTLY. Exact statement of OCCUPATION. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D. 69115 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 69115

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3529 Sweetair St. 13 WARD)

2. FULL NAME George A. Baker

(a) RESIDENCE NO. 3529 Sweetair St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 24 1922

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

10 NAME OF FATHER George W. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) on 4

12 MAIDEN NAME OF MOTHER Marie Bablon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) on 4

14 Informant George A. Baker (Address) 3529 Sweetair St.

15 Filed NOV 11 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct 24th, 1922, to Nov 10th, 1922, that I last saw him alive on Nov 9th, 1922, and that death occurred, on the date stated above, at 7:50 P. M.

The CAUSE OF DEATH* was as follows:

Congenital Aortic Aneurysm

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 17 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. B. T. Lillard, M. D.

11/11, 1922 (Address) 1427 Union St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- DATE OF BURIAL

St. Marys Hampden Nov 11 1922

20 UNDERTAKER ADDRESS

Chenoweth Son Chestnut Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 69116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 69116

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.

2-FULL NAME

(Residence in Baltimore: No.

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH

7-AGE

8-LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country).

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15-

Filed

NOV 12 1922

ROBERT R. KRAUTER,

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

17-

I HEREBY CERTIFY that I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21-MAT-1500 Rks.

D69117

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69117

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 Orleans ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary M. Reiss

(a) RESIDENCE NO. 2716 Orleans ST., WARD

(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. 11 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Reiss

6 DATE OF BIRTH (month, day, and year) Nov 14 = 1860

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 61 11 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER George Weck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Reiss (Address) 2716 Orleans ST.

15 NOV 12 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 9 1922

17 I HEREBY CERTIFY, that I attended deceased from Nov 22 to Nov 22, 1922

that I last saw him alive on Nov 22, 1922

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Jones, M. D.

(Address) 104 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Gale Lawn Cemetery Nov 12 1922

UNDERTAKER

ADDRESS

Henry Lutz N. Broadway

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

69118

HEALTH DEPARTMENT—CITY OF BALTIMORE

69118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Volunteers of America Hospital* ST.: *90* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edwin F. Magness

(a) RESIDENCE. No.

918 Homestead ST.: *90* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

life yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male*

4 COLOR OR RACE *White*

5 Single Married, Widowed, Divorced (If married, give name of spouse)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Minnie A. Magness*

6 DATE OF BIRTH (month, day, and year) *11-2-1858*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. *63 11 9*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Balto Md*

10 NAME OF FATHER *John Magness*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Balto Md*

12 MAIDEN NAME OF MOTHER *Mary Wolley*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Balto Md*

14

Informant (Address) *Minnie A. Magness 918 Homestead Street*

15

NOV 12 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 11* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Sept 30*, 19 *22*, to *Nov 11*, 19 *22*,

that I last saw him alive on *Nov 11*, 19 *22*,

and that death occurred, on the date stated above, at *6 a* m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis

(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Embolus*

(duration) yrs. mos. ds.

18 Where was disease contracted? *?* if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Stethoscope*

(Signed) *Albert S. Conner*, M. D.

, 19 (Address) *Vol. of A. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Loudon Park

11/14/22

20 UNDERTAKER

ADDRESS

Wm Cook

502 E North

69119

HEALTH DEPARTMENT—CITY OF BALTIMORE

69119

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14

Informant (Address)

15

Filed

NOV 12 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw her alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

19 11, 19 22 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

Spec. - 1-10-21 - M&T - 1500 lks.

69120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69120

X44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST. 75 WARD)

2-FULL NAME

(a) RESIDENCE NO. Elkridge, Maryland ST. 5 WARD 5

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carey J. H. Thompson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 65 yrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher.

(b) General nature of industry, business, or establishment in which employed (or employer) 66

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address) Chas. Thompson, Elkridge, Maryland

15

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11-1922

17

I HEREBY CERTIFY, That I attended deceased from 11-6, 1922, to 11-11, 1922.

that I last saw him alive on 11-11, 1922.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

with infarction of myocardium

of the heart

(duration) yrs. 6 mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 6 mos. 11 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of 11-11-22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Thompson, M. D.

, 19 22 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

London Park

Nov. 13 1922

20 UNDERTAKER

ADDRESS

Easton Sons, Ellicott City

THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *21* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1105 - Columbia* St.; yrs. *2 1/2* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-Single,

Married,

Widowed,

or Divorced.

(Write the word.)

Single

6-DATE OF BIRTH

(Month)

(Day)

(Year)

Oct 25 1903

7-AGE

19 yrs.

mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Car body

9-BIRTHPLACE

(State or Country)

Balto

10-NAME OF FATHER

Paul Newton

11-BIRTHPLACE OF FATHER

(State or Country)

Balto

12-MAIDEN NAME OF MOTHER

Lily Hattenberg

13-BIRTHPLACE OF MOTHER

(State or Country)

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Harry Newton
1105 - Columbia

15-

File

NOV 12 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

(Month)

(Day)

192*2*
(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) and that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns - accidental
(house fire)
cause unknown
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *W. H. H. H.* M. D.

(Coroner)

2111 192*2* (Address) *1105 - Columbia*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Western

Nov 13 1922

20-UNDERTAKER

ADDRESS

John Fields 1200 W Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Kenasett ST. 13 WARD)

REGISTERED NO. C

2-FULL NAME

Florence Rayner

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1530 Kenasett St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

white5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Single
(Write the word.)

6-DATE OF BIRTH.

Jan. 16, 1922
(Month) (Day) (Year)

7-AGE,

9 yrs. 25 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Child

9-BIRTHPLACE, (State or Country),

Balto., Md.

10-NAME OF FATHER,

Thos A Rayner

11-BIRTHPLACE OF FATHER (State or Country),

Balto., Md

12-MAIDEN NAME OF MOTHER

Bertha Burkhardt

13-BIRTHPLACE OF MOTHER (State or Country),

Balto., Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Thos A. Rayner(Address) 1530 Kenasett St

15-

Filed NOV 12 1922 ROBERT R. KRAUTER
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

November 10, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 8 1922, to Nov 10 1922that I saw him alive on Nov 10 1922and that death occurred, on the date stated above, at 11:45 a.m.

The CAUSE OF DEATH* was as follows:

Gastric - Enteritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James Brown M. D.11/10, 1922 Address 1837 Penna Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Carmel

DATE OF BURIAL,

Nov 13, 1922

20-UNDERTAKER

John Fields 1200 N Lombard

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *29 N. Streper*ST.: *6* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Catherine White*(Residence in Baltimore: No. *29 N. Streper St*

St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female*4-COLOR OR RACE, *White*5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)6-DATE OF BIRTH, *Jan 27, 1874*

(Month)

(Day)

(Year)

7-AGE, *48*

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work, *at home*

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), *Balto. Md.*10-NAME OF FATHER, *Ligoi Eder*11-BIRTHPLACE OF FATHER (State or Country), *Germany*12-MAIDEN NAME OF MOTHER, *Not Known*13-BIRTHPLACE OF MOTHER (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mr. Thomas J. White*(Address) *29 N. Streper St.*

NOV 12 1922

Filed

191

ROBERT R. KRAUTH,

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 9, 1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from *Nov 8, 1922, to Nov 9, 1922,*that I saw him alive on *Nov 8, 1922,*and that death occurred, on the date stated above, at *440 a.m.*

The CAUSE OF DEATH* was as follows:

*Pyelonephritis
secondary to
nephritis
(Duration) 6 yrs. 6 mos. 6 ds.*

CONTRIBUTORY (Secondary)

*Nephritis
(Signed) Maxwell S. May, M.D.
11/9/22, 191... (Address) 3113 E. Balt.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Calvary Cemetery*DATE OF BURIAL, *Nov. 13, 1922*20-UNDERTAKER, *John J. Iders 156 N. Luzerne*

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph's Hosp.* St. *7* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Hugh B. Armstrong*

(Residence in Baltimore: No. *1007 N. Wolfe* St.; (yrs., *4*) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

Black

Single
Married,
Widowed,
or Divorced,
(Write the word.)

6-DATE OF BIRTH.

Unknown
(Month) (Day) (Year)

7-AGE,

40

yrs. mos. ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

Wm. Hill Co.

9-BIRTHPLACE,

(State or Country).

North Carolina

PARENTS.

10-NAME OF FATHER,

Sam Armstrong

11-BIRTHPLACE OF FATHER,

(State or Country),

N.C.

12-MAIDEN NAME OF MOTHER,

Mary Gates

13-BIRTHPLACE OF MOTHER,

(State or Country),

N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Rosa Reed

(Address)

1007 N. Wolfe

15

NOV 12 1922

ROBERT R. KRAUTER,

Filed

1922

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Nov *10*, 192*2*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *Autopsy* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *Autopsy* (Inquest, autopsy or inquiry.) find that said deceased came to *this* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage - Thoracic due to pistol wound Ball entered above left clavicle.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Nov 13/22 8 30 PM (Duration) yrs. mos. ds.

(Signed) *J. S. Hall* M. D. (Coroner.)

11-12 (Address) *508 E North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

Beards N.C.

Nov 14, 1922

20-UNDERTAKER,

ADDRESS

Mrs. R. A. Elliott

1725 Ashland Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Rhs.

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E. Balto ST., 6 WARD)

2-FULL NAME Mary Goldstein

(a) RESIDENCE NO. 2100 E Balto St. ST., WARD

Length of residence in city or town where death occurred 30 yrs. - mos. - ds. How long in U. S., if of foreign birth? 30 yrs. - mos. - ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE Years 49 Months - Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

10 NAME OF FATHER Jacob Kirshenbaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14

Informant (Address)

15

NOV 12 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 1922, to Nov 11, 1922, that I last saw her alive on Nov 11, 1922, and that death occurred, on the date stated above, at 2 p. m. The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos. ds. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D. Baylin

11/12, 1922 (Address) 710 E. B. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Burial 11/14 1922

20 UNDERTAKER A. Robinson & Bro E. Balto

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.**

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Initial Resuscitation
No other history

D69126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69126

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 920 argyle ave ST. 17 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William K Proctor

(a) RESIDENCE. NO. 920 argyle ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Polond 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertie Proctor

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 50 - -

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer Bennie Franklin

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER Thomas Proctor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Birdie Proctor (Address) 920 argyle ave

15 Filed NOV 12 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11 - 8 - 1922

17 I HEREBY CERTIFY, That I attended deceased from 11:30 AM 1922 to 4:00 PM 1922 that I last saw him alive on 11-8-1922 and that death occurred, on the date stated above, at 7:30 PM. The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Bauman M. D.

, 19 (Address) 1043 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt. Auburn

DATE OF BURIAL

Nov 12 1922

20 UNDERTAKER

John H. Trudwin

ADDRESS

142 W. Hill St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Burial Permit Clerk

969127

HEALTH DEPARTMENT—CITY OF BALTIMORE

969127

CERTIFICATE OF DEATH.

34

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *St Joseph 1405* ST. *26* WARD)2. FULL NAME *Gorothy Poffel*(a) RESIDENCE NO. *316 Delaware* ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *Nov 28 1906*

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*15**11**12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)*Baltimore*10 NAME OF FATHER *Henry Poffel*

11 BIRTHPLACE OF FATHER (city or town)

*Poland*12 MAIDEN NAME OF MOTHER *Jda Henderson*

13 BIRTHPLACE OF MOTHER (city or town)

Poland

14

Informant *Mr Henry Poffel*(Address) *316 Delaware and Baltimore*

15

Filed

NOV 12 1922

ROBERT R. KRAUTER

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 10 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*Apr 22 1922 to Nov 10 1922*that I last saw her alive on *Nov 10 1922*and that death occurred, on the date stated above, at *3:02 P* m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
(duration) yrs. mos. *11* ds.CONTRIBUTORY
(Secondary)*Subarterial Atherosclerosis of spine*
(duration) yrs. *7* mos. *19* ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy?

What test confirmed diagnosis? *X-ray*

(Signed)

19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*John M. Weber**Nov 13 1922*
1803 Bank St

Physicians should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Hk.

069/28 HEALTH DEPARTMENT—CITY OF BALTIMORE 069/28
90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2520 Foster ave ST. 1 WARD)

2-FULL NAME *Rikodem Stalenski*

(a) RESIDENCE No. 2520 Foster ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male white widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 1852

7 AGE Years Months Days If LESS than 1 day, hrs or min.
70 5 22

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant

Mrs. Johanna Wolinski
2520 Foster ave

15

Filed

NOV 12 1922

ROBERT H. KRAUTH

Bureau of Health

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1922

17

I HEREBY CERTIFY That I attended deceased from Nov 9 1922 to Nov 11 1922 that I last saw him alive on Nov 11 1922

and that death occurred, on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Vascular Disease

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Weber, M. D.

19 PLACE OF BURIAL CREMATION OR RE-MOVAL

DATE OF BURIAL

Nov 14 1922

John Weber

1803 Bank St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hebrew Hospital*

REGISTERED NO.

CITY OF BALTIMORE: (No. *Monument St + Rutland Ave* ST. *6* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Louis Hlavin* (HLAVIN)(a) RESIDENCE. NO. *402* *N. Belwood* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Abelina Hlavin

6 DATE OF BIRTH (month, day, and year)

Oct 29 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Joseph Hlavin

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Bohemia

12 MAIDEN NAME OF MOTHER

Net Kroon

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bohemia

14

Informant (Address)

Abelina Hlavin
1402 N. Belwood

15

Filed

19

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 10* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *October 29* 19 *22*, to *Nov. 8* 19 *22*.that I last saw him alive on *Nov 8* 19 *22*.and that death occurred, on the date stated above, at *12:20 a.m.*

The CAUSE OF DEATH* was as follows:

Uremia(duration) yrs. mos. *10* ds.CONTRIBUTORY *Acute Nephritis*
(Secondary)(duration) yrs. mos. *10* ds.18 Where was disease contracted if not at place of death? *at home*Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *Signatory tests*(Signed) *Moses Sellman* M. D., 19 (Address) *Hebrew Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

*Holy Redeemer**Nov. 13 1922*

20 UNDERTAKER

Frank Crochsen

ADDRESS

1406 Belmont

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 12 1922

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assoc.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma, Sarcoma, etc.*, of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Chronic Nephritis
No other history

HEALTH DEPARTMENT - CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Balto General Hospital 16* ST., *16* WARD)2. FULL NAME *Mrs Mary A. Gerwig*(a) RESIDENCE No. *1028 N Fulton Ave* ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred *6* yrs. - mos. - ds.REGISTERED NO. *57-269130*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Jacob H Gerwig*6 DATE OF BIRTH (month, day, and year) *Nov 4 1861*7 AGE *61* Years Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED *Housewife*

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore Md* (State or country)10 NAME OF FATHER *Patrick Manning*11 BIRTHPLACE OF FATHER (city or town) *Ireland* (State or country)12 MAIDEN NAME OF MOTHER *Margaret Carey*13 BIRTHPLACE OF MOTHER (city or town) *Ireland* (State or country)

14

Informant *Jacob H. Gerwig* (Address) *1028 N. Fulton Ave*

15

Filed *Nov 12 1922*

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 10 1922*

17

I HEREBY CERTIFY, That I attended deceased from

*November 7, 1922, to November 10, 1922*that I last saw him alive on *November 10, 1922*and that death occurred, on the date stated above, at *11:09 a.m.*

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Diabetes*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *November 10, 1922*Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John A. O'Connor*, M. D., 19 *1922* (Address) *South Balto Gen Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Western Bur.*DATE OF BURIAL *Nov 13 1922*20 UNDERTAKER *Mrs. Chas A G Ralder*ADDRESS *1028 N. Fulton Ave*

State of Maryland, *City of Balto* to wit:

BE IT REMEMBERED, That on this *16th* day of *Nov*
A. D., 1912, before me the subscriber, a *Notary Public*
of the said state, in and for the *City* aforesaid, personally appeared
Jacob F. Gerwig.

and made oath in due form of law that *his wife Mary A. Gerwig*
was born Nov. 4, 1861.

Witness D. F. Carter.

Jacob F. Gerwig

My commission expires May 1924.

CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 161 N. Cross ST. 23 WARD)

2-FULL NAME

(Residence in Baltimore: No. 161 N. Cross St.; yrs., mos., ds.)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Single

6-DATE OF BIRTH,

July 2, 1922

(Month)

(Day)

(Year)

7-AGE,

yrs. 4 mos. 9 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,

(State or Country),

Balto

10-NAME OF FATHER,

Charles Henry Kochulem

11-BIRTHPLACE OF FATHER

(State or Country),

Balto

12-MAIDEN NAME OF MOTHER

Mrs. Pumphrey

13-BIRTHPLACE OF MOTHER

(State or Country),

Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Charles Henry Kochulem

(Address)

161 N. Cross St.

15-

Filed

NOV 12 1922

ROBERT R. KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov 11, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov 8 1922, to Nov 11 1922,

that I saw him alive on Nov 11 1922,

and that death occurred, on the date stated above, at 5:21 m.

The CAUSE OF DEATH* was as follows:

Cerebral

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Entire

(Duration) yrs. mos. ds.

(Signature) John D. Koll M. D.

(Address) 1202 E. 1st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

St. Agnes

Nov 13, 1922

20-UNDERTAKER

ADDRESS

Wm. T. Tichner & Co.

North Ave

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 6-9-19 H. P. C. 1000 Rev.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sister of St. Paul* 10)

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *James Ohler*

(a) RESIDENCE. NO. *Preslar Valley Ho.* ST..

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorred (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

May E. Nolas

6 DATE OF BIRTH (month, day, and year) *July 18th 1835*

7 AGE Years *87* Months *3* Days *23* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Canoe C.* (State or country) *Ind.*

10 NAME OF FATHER *Abraham Ohler*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Ind.*

12 MAIDEN NAME OF MOTHER *Margaret Hahn*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Ind.*

14 Informant *Sister Florence* (Address) *Little Sister of St. Paul*

15 *NOV 12 1922* *ROBERT B. KRAUTER* Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *10/11* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from

10/11 19*22* to *10/11* 19*22*

that I last saw him alive on *10/9* 19*22*

and that death occurred, on the date stated above, at *3.30 P. m.*

The CAUSE OF DEATH* was as follows:

Coronary atherosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Arteriosclerosis*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. H. Warner* M. D.

. 19 (Address) *1133 Valley St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

St. Johns Long Green Row 13 19*22*

20 UNDERTAKER *H. C. Wiedefeld* ADDRESS *914 Greenmount*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159182

69134

CERTIFICATE OF DEATH.

69134
X 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Evelyn K. Cadden

(a) RESIDENCE NO. Spawns Pt. Rd. ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) May 22, 1922

7 AGE Years 5 Months 20 Days _____ If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore (State or country) County

10 NAME OF FATHER Theodore K. Cadden

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country) _____

12 MAIDEN NAME OF MOTHER Sarah Bond

13 BIRTHPLACE OF MOTHER (city or town) Pennsylvania (State or country) _____

14 Informant JOHNS HOPKINS HOSPITAL (Address) _____

15 NOV 13 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct 19, 19 22 to Nov 11, 19 22.

that I last saw her alive on Nov 11, 19 22.

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Diarrhoea - not dysentery

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Spawns Point Road near Edgemoor

Did an operation precede death? no Date of _____

Was there an autopsy? Yes

What test confirmed diagnosis? _____

(Signed) H. H. Weech M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Carmel Cemetery

DATE OF BURIAL

20 UNDERTAKER John F. Denny

Nov 14 19 22

ADDRESS 715 L. S. St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maternity Hosp) WARD 9

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby March(Residence in Baltimore: No. Pittsburg St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

W5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)
Baby

6-DATE OF BIRTH,

Nov 8, 1922
(Month) (Day) (Year)

7-AGE,

3 yrs., mos. ds.If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE,
(State or Country),
Balto. Md.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),
Germany12-MAIDEN NAME OF MOTHER
Mamie March13-BIRTHPLACE OF MOTHER
(State or Country),
Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. R. Stromberger R.N.(Address) West End Maternity Hosp

15-

Filed

191

ROBERT R. KRAUTER,

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov 11, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov 8 1922, to Nov 11 1922,that I saw her alive on Nov 11 1922,and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) William J. Moran M.D.Nov 11, 1922 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Oak Lawn Cem Nov 13, 1922

20-UNDERTAKER

ADDRESS 3000 E. Baltich

Important. See instructions on back of certificate.

269136

HEALTH DEPARTMENT—CITY OF BALTIMORE

269136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Linwood Ave ST., 6 WARD)

2-FULL NAME

Mary G. Baldwin

(a) RESIDENCE No.

21 N. Linwood Ave ST., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Wm. H. Baldwin

6 DATE OF BIRTH (month, day, and year)

Aug. 31-1881

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

41 2 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

City

10 NAME OF FATHER

Patrick Booney

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Sarah Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Scotland

14

Informant (Address)

Mrs. Sarah Booney
21 N. Linwood Ave

15

Filed

NOV 13 1922

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Sept 12, 19 22 to Nov 10, 19 22.

that I last saw her alive on Nov 10, 19 22.

and that death occurred, on the date stated above, at 7 30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Chronic Endocarditis

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed)

J. W. Keel, M. D.

Nov 12 1922 (Address) 100 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery Nov 13 1922

20 UNDERTAKER

ADDRESS

John A. Moran

300 E. Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

Former or usual residence.....	
19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL,
London Park Cemetery	Nov 30 1922
20-UNDERTAKER.	ADDRESS
Geo Lewis Baker	64712 Bent

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

Charnasky
269138 HEALTH DEPARTMENT—CITY OF BALTIMORE *269138*

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Woman's Hospital*

CITY OF BALTIMORE: (No. *5* ST., *5* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Elizabeth Charnasky*

(a) RESIDENCE NO. *817 E. Pratt St.*
(Usual place of abode)

ST., _____ WARD _____
(If non-resident give city or town and State)

Length of residence in city or town where death occurred *20* yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? *10* yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 *Single, Married, Widowed, or Divorced, (write the word)* *married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *John Charnasky*

6 DATE OF BIRTH (month, day, and year) *unknown*

7 AGE Years *28* Months *unknown* Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Lithuania*
(State or country)

10 NAME OF FATHER *Adam Vencukunas*

11 BIRTHPLACE OF FATHER (city or town) *Lithuania*
(State or country)

12 MAIDEN NAME OF MOTHER *Agnes Swirplis*

13 BIRTHPLACE OF MOTHER (city or town) *Lithuania*
(State or country)

14 Informant *John Charnasky*
(Address) *817 E. Pratt St.*

15 Filed *131922* 19 *22* Registrar *John G. G. G.*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 11* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from *Nov 10*, 19 *22*, to *Nov 11*, 19 *22*, that I last saw her alive on *Nov 11*, 19 *22*.

and that death occurred, on the date stated above, at *10:25 A. m.*

The CAUSE OF DEATH* was as follows:

General peritonitis

CONTRIBUTORY (Secondary) *Acute appendicitis* (duration) _____ yrs. _____ mos. *2* ds.

(duration) _____ yrs. _____ mos. *4* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *Nov 10, 1922*

Was there an autopsy? *No.*

What test confirmed diagnosis? *Operation*
(Signed) *Norman E. Tannenbaum, M. D.*

, 19 (Address) *Woman's Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL *Holy Redeemer* DATE OF BURIAL *Nov 14 1922*

20 UNDERTAKER *John G. G. G.* ADDRESS *725 S. Pratt St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.69139 HEALTH DEPARTMENT—CITY OF BALTIMORE D.69139

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 15 Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Myrtle Carter Schopp

(Residence in Baltimore: No. 1730 N. Calhoun St. St. yrs. mos. ds.)
Life

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female
4-COLOR OR RACE, White
5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH, February 1, 1898
(Month) (Day) (Year)

7-AGE, 24 yrs. 9 mos. ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer). Eisenberg's Dept. Store

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS
10-NAME OF FATHER, George W. Carter
11-BIRTHPLACE OF FATHER, (State or Country). Baltimore, Md.
12-MAIDEN NAME OF MOTHER, Emma Stubbs
13-BIRTHPLACE OF MOTHER, (State or Country). Baltimore, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. J. Carter

(Address) 1730 N. Calhoun St.

15- NOV 13 1922 ROBERT R. KRAUTER,
Filed 1922 Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, November 9th, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said Inquest, autopsy or inquiry, I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide
Bucklone Mercury
Ac Neptunite
420. Chiswick Blades
Nov. 9, 1922 (Address) 143 N. Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, London Park Co. DATE OF BURIAL, Nov. 13, 1922

20-UNDERTAKER, Joseph B. Cook ADDRESS, 1003 N. Baltimore

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Baby Smith* ST. *22* WARD)

2-FULL NAME

(a) RESIDENCE. NO. *109 W. Perry* ST. *22* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., If of foreign birth?

(If nonresident give city or town and State)

yrs. mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

*Col*5 Single, Married, Widowed,
or Divorced (write the word)5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

July 27-1862

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.*4**4*

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14

Informant
(Address)

15

Filed

19

Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

11/11/22

17

I HEREBY CERTIFY, That I attended deceased from
11/2/22 to *11/11/22*
that I last saw him alive on *11/11/22*
and that death occurred, on the date stated above, at *6:30 P. m.*

The CAUSE OF DEATH* was as follows:

Acute Stomatitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

11/13/22
19 (Address)*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hospital* ST. *70* WARD)

2-FULL NAME

Oscar Beck(a) RESIDENCE No. *230 Collins Ave.* ST. *70* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. *2* mos.

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M.

4 COLOR OR RACE

W.

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Sept 13 1912*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*10**2**2*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Do not know

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

" "

12 MAIDEN NAME OF MOTHER

" "

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

" "

14

Informant (Address)

Mrs. Beck 230 Collins Ave.

15

Filed

NOV 13 1922

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *11-11-1922*

17

I HEREBY CERTIFY, That I attended deceased from

11-7-22 to *11-11-22*that I last saw him alive on *11-11-22*and that death occurred, on the date stated above, at *2:30 P.M.*

The CAUSE OF DEATH* was as follows:

Acute appendicitis - Gangrenous with peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY *Double Broncho-pneumonia*(Secondary) *monia - Contingent failure of**Respiratory system* (duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? *Home*Did an operation precede death? *yes* Date of *11-7-22*Was there an autopsy? *No*What test confirmed diagnosis? *Operation - Clinical*(Signed) *W.C. Caldwell* M. D., 19 (Address) *St. Agnes Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

*Woodlawn Cemetery**Nov 14 1922*

20 UNDERTAKER

ADDRESS

*for Frederickson Son**2078 Bay*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Physicians should state EXACTLY, PHYSICIANS should be stated EXACTLY, AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19-H. P. Co.-1000 Bks.

069142

HEALTH DEPARTMENT—CITY OF BALTIMORE

069142

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Univ. Hospital* ST. *2* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. *833* St. *Ostend* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *10* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male Colored Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Labour

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 8* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *October 8*, 19 *22*, to *Nov. 8*, 19 *22*.

That I last saw him alive on *Nov. 8*, 19 *22*.

and that death occurred, on the date stated above, at *11:40 P.M.*

The CAUSE OF DEATH was as follows:

Intestinal Obstruction

(duration) yrs. *one* mo. ds.

CONTRIBUTORY (Secondary)

Terminal uremia

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

home

Did an operation precede death?

yes Date of *Oct. 9th*

Was there an autopsy?

no

What test confirmed diagnosis?

Urinary, chemical findings

(Signed)

J. C. Hall

M. D.

19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Charles

Nov. 13, 1922

20 UNDERTAKER

Geo. A. W. W. W.

ADDRESS

1303

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1821 Kavanaugh ST.: 15 WARD) REGISTERED NO. 74-001
(If death occurred in a hospital or institution, give its NAME instead of street and number.)
2-FULL NAME Julia Dickerson
(a) RESIDENCE. NO. 1821 Kavanaugh ST. 15 WARD. 15
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 15 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>F.</u>	4 COLOR OR RACE <u>Colored</u>	5 Single, Married, Widowed, or Divorced (write the word) <u>Single</u>		
5a If married, widowed, or divorced HUSBAND of _____ (or) WIFE of _____				
6 DATE OF BIRTH (month, day, and year) <u>Dec 10th - 1875</u>				
7 AGE	Years <u>46</u>	Months <u>11</u>	Days <u>2</u>	If LESS than 1 day, hrs. or min.
8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work <u>Houseworker</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>070</u> (c) Name of employer				
9 BIRTHPLACE (city or town) (State or country) <u>Va</u>				
10 NAME OF FATHER <u>Unknown</u>				
11 BIRTHPLACE OF FATHER (city or town) (State or country) <u>Va</u>				
12 MAIDEN NAME OF MOTHER <u>Unknown</u>				
13 BIRTHPLACE OF MOTHER (city or town) (State or country) <u>Va</u>				
14 Informant <u>Mrs Clara Dickerson</u> (Address) <u>1821 Kavanaugh</u>				
15 Filed <u>NOV 13 1922</u> <u>ROBERT R. KRAUTER</u> Registrar				

MEDICAL CERTIFICATE OF DEATH
16 DATE OF DEATH (month, day, and year) <u>Nov 12th 1922</u>
17 I HEREBY CERTIFY, That I attended deceased from <u>Nov 6th 1922</u> , to <u>Nov 12th 1922</u> , that I last saw him alive on <u>Nov 12th 1922</u> , and that death occurred, on the date stated above, at <u>4:17 A</u> m. The CAUSE OF DEATH* was as follows: <u>Cerebral Compression</u> <u>(Apoplexy)</u> (duration) yrs. mos. ds. <u>6</u> CONTRIBUTORY <u>Arterial Sclerosis</u> (Secondary) (duration) yrs. mos. ds. <u>6</u> 18 Where was disease contracted if not at place of death? <u>yes</u> Did an operation precede death? <u>no</u> Date of _____ Was there an autopsy? <u>no</u> What test confirmed diagnosis? <u>Symptomatology</u> (Signed) <u>Justus W. Bell</u> M. D. , 19 (Address) <u>1224 N. Filmore St.</u> *State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) 19 PLACE OF BURIAL, CREMATION OR REMOVAL <u>Mr. Auburn</u> DATE OF BURIAL <u>Nov 14 1922</u> 20 UNDERTAKER <u>Geo. H. Lewis</u> ADDRESS <u>303</u>

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

269144

HEALTH DEPARTMENT—CITY OF BALTIMORE

269144

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3009 Eastern Ave.

ST.: 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Hinton

(a) RESIDENCE. No. 3009 Eastern Ave.

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos.

ST. WARD.

(If nonresident give city or town and State)

ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine L. Hinton

6 DATE OF BIRTH (month, day, and year) July 24, 1853

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 69 3 17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stove Mounter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Gas Appliance Co.

9 BIRTHPLACE (city or town) Balto. City (State or country) Md.

10 NAME OF FATHER Wm. A. Hinton,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie R. Hunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs. Mary Adams, (Address) 3009 Eastern Ave.

15 Filed NOV 13 1922 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/10 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1922, to Nov 10, 1922, that I last saw him alive on Nov 10, 1922, and that death occurred, on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows: Acute Endocarditis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Leucocytes

(Signed) William S. Fisher, M. D.

, 19 (Address) 3325 Park Rd. An

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Nov. 13 1922

20 UNDERTAKER Wm. C. Black 927 N. Broadway

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Probably Tuberculosis
of Lungs.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *7 Spring Ave. Raspeburg* ST. *WARD*)2-FULL NAME *Mary A. Lamb.*(a) RESIDENCE NO. *7 Spring Ave. Raspeburg* ST. *WARD*

(Usual place of abode)

Length of residence in city or town where death occurred *67* yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Married

6a If married, widowed, or divorced

HUSBAND of (or) WIFE of

James S. C. Lamb.

6 DATE OF BIRTH (month, day, and year)

March 20 1853

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*69**7**22*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Boston Mass.

10 NAME OF FATHER

Mr. J. Edmeades

11 BIRTHPLACE OF FATHER (city or town) (State or country)

*Rochester**England*

12 MAIDEN NAME OF MOTHER

Elizabeth G. Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

*London**England*

14

Informant (Address)

James S. C. Lamb 7 Spring Ave. Raspeburg

15

Filed *NOV 13 1922*

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from

*Nov. 4, 1922, to Nov. 11, 1922,*that I last saw him alive on *Nov. 11, 1922,*and that death occurred, on the date stated above, at *7 P. m.*

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Rt. upper lobe)(duration) yrs. mos. *7* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

no

Date of

Was there an autopsy?

no

What test confirmed diagnosis?

(Signed)

A. S. Williamson

M. D.

(Address) *13 Bel Air Rd., Raspeburg.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

Baltimore Cemetery Nov 14 1922

20 UNDERTAKER

ADDRESS

Frederick L. Loeber Sons Fullerton

CERTIFICATE OF DEATH.

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 439 N. Remond St. WARD 16
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11 1922

17 I HEREBY CERTIFY, That I attended deceased from July, 1922, to Nov 11, 1922. that I last saw her alive on Nov 11, 1922 and that death occurred, on the date stated above, at 8:40 A. m. The CAUSE OF DEATH* was as follows:

The CAUSE OF DEATH* was as follows:

Утренняя

(c) **Name of employer**

13 BIRTHPLACE OF MOTHER (city or town) German
(State or country)

15
NOV 13 1922
Filed
Registrar

Philip Harris

D69147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69147

91-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1440 N Bond

ST., 8

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Isabella E. Shiller

(a) RESIDENCE NO.

1440 N. Bond.

ST.

WARD

(Usual place of abode)

Length of residence in city or town where death occurred

Life yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

87.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

Md

10 NAME OF FATHER

Wadde

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Norway

12 MAIDEN NAME OF MOTHER

Fannie Wounco

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Balto

Md

14

Informant (Address)

Frank Gibbons 1440 N. Bond.

15

Filed

1922

17 Jan

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 12 1922

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1921, to Nov 12, 1922, that I last saw him alive on Nov 11, 1922,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Edward J. Leach

M. D.

(Address)

413 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Carmel Cemetery

Nov 14, 1922

20 UNDERTAKER

ADDRESS

Robt J Turner Inc

1442 Broadway

269148

HEALTH DEPARTMENT—CITY OF BALTIMORE

269148

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 142 W. Lanvale ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katharine Hutchins

(a) RESIDENCE NO. 142 W. Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Harmon Hutchins

6 DATE OF BIRTH (month, day, and year) Aug. 11, 1842

7 AGE Years 80 Months 3 Days 0 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER George I. Kennard

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Mary Eleanor Poe

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14

Informant Miss Katharine K. Hutchins (Address) 142 W. Lanvale Street

Filed NOV 13 1922

H. W. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct 15, 1922, to Nov 12, 1922.

that I last saw him alive on Nov 12, 1922

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

Cardiac Decompensation

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George H. Lane, M. D.

, 19 (Address) 1000 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Druid Ridge Cemetery

DATE OF BURIAL

11/14 1922

20 UNDERTAKER

Henry W. Years & Son 805 N. Calvert

is very important. See instructions on back of certificate.

D69149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Goldman Hospital* St. *19* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Florence P. Jones*

(Residence in Baltimore: No. *324 S. Parrish St.* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced *Married*
(Write the word)

6-DATE OF BIRTH *Unknown*
(Month) (Day) (Year)

7-AGE *35*
yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Housewife*
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) *Bald City*

10-NAME OF FATHER, *Mr. Roberts*

11-BIRTHPLACE OF FATHER, (State or Country) *Bald City*

12-MAIDEN NAME OF MOTHER, *Unknown*

13-BIRTHPLACE OF MOTHER, (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Florence P. Jones*

(Address) *324 S. Parrish St.*

15- *Nov 13 1922* 192 *22*

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 12*, 192 *22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said... (Inquest, autopsy or inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) *4 or 5 days* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Heart Disease*

(Duration) *12 or 13 years* yrs. mos. ds.

(Signed) *W. H. Jones* M. D.

(Coroner)

192... (Address) *11-12 S. Saint St.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death... yrs. mos. ds. In the State... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR CREMATION, *Goldown Park*

DATE OF BURIAL, *Nov 14 1922*

20-UNDERTAKER, *William Cook*

ADDRESS *502 E. North St.*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-MAT 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Shaw

(a) RESIDENCE NO. Unknown

(Usual place of abode)

ST. 76 WARD 129

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE Years 72 Months -- Days -- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertising man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant Hospital Records,
(Address) Municipal Hospital.

15

Filed 11/13/22, 19 22

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 19 22

17

I HEREBY CERTIFY, That I attended deceased from November 2, 19 22, to November 11, 19 22, that I last saw him alive on November 11, 19 22, and that death occurred, on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

CONTRIBUTORY (Secondary) Chronic myocarditis
(duration) 1 yrs. mos. ds.

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Clayton M. Neel

M. D.

11/13/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Greenmt. 11/14/1922

20 UNDERTAKER

ADDRESS

Wm. Lewis, 5026 North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T 1500 Bks.

869151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 869151

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 28 WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice McGinnis

(a) RESIDENCE No. 4203 Ridgewood Ave ST. _____ WARD _____
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of Wm. J. McGinnis or WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Aug 1871

7 AGE Years 41 Months -- Days -- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

10 NAME OF FATHER Frank Tucker

11 BIRTHPLACE OF FATHER (city or town) Virginia
(State or country)

12 MAIDEN NAME OF MOTHER Ida Wiley

13 BIRTHPLACE OF MOTHER (city or town) Virginia
(State or country)

14 Informant Hospital Records,
(Address) Municipal Hospital.

15 Filed NOV 13 1922 ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 19 22

17 I HEREBY CERTIFY, That I attended deceased from November 3, 19 22 to November 12, 19 22, that I last saw her alive on November 12, 19 22, and that death occurred, on the date stated above, at 12:45 P.M. The CAUSE OF DEATH* was as follows:

Epidemic encephalitis

(duration) yrs. mos. ds. 10
CONTRIBUTORY Acute alcoholism
(Secondary)

(duration) yrs. mos. ds. 7
18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Cholera
(Signed) Chas. McNeil M. D.

11/13/22 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Weston Cem.

DATE OF BURIAL

11/15 19 22

20 UNDERTAKER

McGinnis (Carell 4203 Ridgewood Ave)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

269152 HEALTH DEPARTMENT - CITY OF BALTIMORE 269152

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church home - 90
CITY OF BALTIMORE: (No. Broadway & Fairmount - WARD)
2-FULL NAME Miss Laura Wolfe.
(a) RESIDENCE NO. Church home - 90 ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 9, 1844

7 AGE Years 78 Months 7 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Westminster (State or country) Maryland

10 NAME OF FATHER William Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Hester A. Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md

14 Informant Mrs. M. L. Wellham (Address) 543 N. Carey St.

15 NOV 13 1922 ROBERT A. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1922, to Nov. 12, 1922, that I last saw her alive on Nov. 12, 1922, and that death occurred, on the date stated above, at 9:10 A.M. The CAUSE OF DEATH* was as follows:

Asthma -
Emphysema -
Edema Lungs -
(duration) 2 yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of -

Was there an autopsy? yes -

What test confirmed diagnosis? Clinical Methods
(Signed) Richard G. Cabell, M. D.
, 19 (Address) Church Home - 90

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminister, Md DATE OF BURIAL 11-14-22 19

20 UNDERTAKER E. E. Hughes 404 N. Broadway ADDRESS

11. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

10.69153
D69153

HEALTH DEPARTMENT--CITY OF BALTIMORE

10.69153
D69153

PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No. 918 S. Charles

ST. 73 WARD

2-FULL NAME

(Residence in Baltimore: No. 918 S. Charles St.

St. 63 yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX 7 4-COLOR OR RACE W 5-SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) M.

6-DATE OF BIRTH Sept 8, 1856 (Month) (Day) (Year)

7-AGE 66 yrs. 2 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work House work (b) General nature of industry, business, or establishment in which employed (or employer) At Home

9-BIRTHPLACE (State or country) Maryland

10-NAME OF FATHER George Rieger

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Lena M. Henning

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Strupp (Address) 918 S. Charles St

15

Robert P. Harrison,

REGISTRAR

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH 11/11-1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 11/10-1922, to 11/11-1922.

that I saw her alive on 11/11-1922, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Distal Aortic Aneurysm

Contributory (SECONDARY) (Duration) yrs. 3 mos. ds.

(Signed) (Address) 1223 1/2 W. 1st St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death? Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Cedar Hill

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

John P. Denny

715 Light St

131922

20.69154

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.69154

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2716 O'Donnell

ST.

WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Stanislaw Marecka

(a) RESIDENCE. No.

2716 O'Donnell St.

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

40 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Female White

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 13-1867

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

54

11

28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Poland

10 NAME OF FATHER

Kaczmarecki

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Poland

12 MAIDEN NAME OF MOTHER

Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Poland

14

Informant (Address)

Philip Marecki 2716 O'Donnell St.

15

Filed

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 10 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 7, 1922, to Nov 10, 1922

that I last saw him alive on Nov 8, 1922

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Signs

(Signed) J. J. McAnoy, M. D.

, 19 (Address) 839 D. E. Howard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Stanislaus Cem

Nov-14 1922

20 UNDERTAKER

ADDRESS

Stephen J. Walkowski

1000 S. Pennsylvania Ave

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69155

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *North or South Baltimore* St. *or* Ward)

Registered No. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *male* 4-COLOR OR RACE. *white* 5-Single, Married, Widowed, or Divorced. (Write the word.) *Single*

6-DATE OF BIRTH. 1. (Month) (Day) (Year)

7-AGE. *about 60* If LESS than 1 day, hrs. or min. 2 yrs. mos. ds.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) *087*

9-BIRTHPLACE. (State or Country). *Poland*

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country). *Poland*

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Robert F. Harrison,

181022

1922

Burial Permit Clerk.

Registrar.

THE MORNING.

19648

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Oct 31* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said. (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

..... (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds. (Signed) M. D. (Coroner) 1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.

DATE OF BURIAL.

HOPKINS HOSPITAL

19

20-ADDRESS

ADDRESS

11111111111111111111

NOV 13 1922

D69156

HEALTH DEPARTMENT—CITY OF BALTIMORE D69156

CERTIFICATE OF DEATH. 86-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1101 Buntwood Ave. 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Thorne

(a) RESIDENCE. No. 1101 Buntwood Ave.

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank J. Thorne

6 DATE OF BIRTH (month, day, and year) June 11-1868

7 AGE 54 Years 5 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Edward O'Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Croghan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Daughter (Address) 1101 Buntwood Ave.

15 Filed 131522 ROBERT P. HARRISON, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-11 1922

17 I HEREBY CERTIFY, That I attended deceased from 10/30/22, 19 to 11/11, 1922, that I last saw him alive on 11-10, 1922.

And that death occurred, on the date stated above, at 830 P. m.

The CAUSE OF DEATH* was as follows:

Septic meningitis (duration) yrs. 3 mos. ds.

CONTRIBUTORY Chronic Suppurative Otitis media (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-5-22 ago

Was there an autopsy? No

What test confirmed diagnosis? Chs Suppurative Otitis with extension to brain

(Signed) Dr. Bernard Weiss, M. D.

, 19 (Address) 914 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Cross Church Nov. 14 1922

20 UNDERTAKER ADDRESS

J. C. Windfield 914 Biddle St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 W. Franklin St.

ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Viola Oliver Tunstalle

(a) RESIDENCE NO. 1726 W. Franklin St.

(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negro

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 25 1922

7 AGE

Years

Months

Days

8

12

If LESS than
1 day, hrs
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER Burre Lewis Tunstalle

11 BIRTHPLACE OF FATHER (city or town) Dunnsville
(State or country) Essex Co. Va.

12 MAIDEN NAME OF MOTHER Olga N. Lee

13 BIRTHPLACE OF MOTHER (city or town) Richmond Va.
(State or country)14 Informant Lewis H. Tunstalle
(Address) 710 N. Stocton St.15 Filed Robert P. Harrison
1922 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/12/22 19

17

I HEREBY CERTIFY, That I attended deceased from
11/11/22, 19 to 11/12/22, 19

that I last saw her alive on 11/12/22, 19

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho- Pneumonia

(duration) yrs. mos. ds. 5

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No. Date of.

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Mant Ave

Nov 14 1922

20 UNDERTAKER

ADDRESS

John H. Owens

538 Dolphin St.

D69158

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

EATH
DRE. No. *517 N Carey* ST. *16*
Frank Gregory Hewitt

WARD

(Usual place of rhode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred			How long in U. S., if of foreign birth?		
yrs.	mos.	ds.	yrs.	mos.	ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11. 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1, 19 22, to Nov. 11, 19 22, that I last saw him alive on Sept. 11, 19 22.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

RECEIVED
JAN 10 1964

CONTRIBUTORY
(Secondary)

Actual Employer Co.

Baltimore

2nd.

curt

(city or town) ...
24-1115a

14 June 1914

Informant
(Address)

Robert F. Harrison

Kind

19

Registrar

Funeral Permit Clerk

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

19

D69159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH

Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.

WARD)

2-FULL NAME

Miss Laura Chornet

(a) RESIDENCE. No.

310 Brestman

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

19

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

19

(If nonresident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1902

7 AGE

20

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Clerk + Office work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Vienna

10 NAME OF FATHER

Egnat Chornet

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Austria

12 MAIDEN NAME OF MOTHER

Eldel Senty

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant (Address)

Jack Lewis 1439 E. Balt.

15

Filed

NOV 14 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

11-12

19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Nov. 10* *1922*, to *Nov. 12*, *1922*

that I last saw her alive on *Nov. 12*, *1922*

and that death occurred, on the date stated above, at *12:55 P.M.*

The CAUSE OF DEATH* was as follows:

Bronchiectasis

(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Broncho Pneumonia

(duration) yrs. mos. ds. *3*

18 Where was disease contracted

if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Ernest Edlauteh*, M. D.

(1-2 1922 Address) *Hebrew Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balt Hebrew Cem

DATE OF BURIAL

11/14 19*22*

20 UNDERTAKER

Jack Lewis 1439 E. Balt.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-MAT-1920 Hk.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69160

CERTIFICATE OF DEATH.

90 D69160

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. *529 S. Port* ST., *1* WARD)

2-FULL NAME

Fredericka Semmler

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

529 S. Port

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *57* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Widowed*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of *William Semmler*

6 DATE OF BIRTH (month, day, and year) *May 31, 1847*

7 AGE Years *75* Months *6* Days *11* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *At home*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Not known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Not known

14 Informant

(Address) *Louisa Hoffmann*

15 *NOV 14 1922* ROBERT R. KRAUTER

Filed

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 11 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Jan 2*, 19*21*, to *Nov 11*, 19*22*, that I last saw her alive on *Nov 6*, 19*22*

and that death occurred, on the date stated above, at *54* m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

To my knowledge (duration) yrs. mos. ds.

CONTRIBUTORY *Intermittent* (Secondary) *at least 15 yrs* (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *Dr. Knobel* M. D.

, 19 (Address) *391 S. Ellwood Ave*

*State the Disease Causing Death or its Death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL *St. Bernard Cem.*

DATE OF BURIAL

Nov 14 1922

20 UNDERTAKER

H. Sander Sons

ADDRESS

1210 Pearl St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69161

CERTIFICATE OF DEATH.

D69161

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 S. Maderia ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth H. Kues(a) RESIDENCE No. 413 S. Maderia ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb 12 - 19217 AGE Years 1 Months 8 Days 29 If LESS than 1 day, hrs. 0 or min. 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None(b) General nature of industry, business, or establishment in which employed (or employer) infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md10 NAME OF FATHER Claude C. Kues11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md12 MAIDEN NAME OF MOTHER Mario Gulack13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14

Informant Claude Kues
(Address) 413 S. Maderia St

15

Filed Nov 14 1922 Registrar Robert H. Kauter

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 1, 19 22, to Nov 11, 19 22,that I last saw him alive on Nov 11, 19 22,and that death occurred, on the date stated above, at 7⁰⁰ A. m.

The CAUSE OF DEATH* was as follows:

Cerebral
Hydrocephalus
(duration) 10 yrs. 0 mos. 0 ds.CONTRIBUTORY (Secondary) Hydrocephalus
(duration) 2 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? (Signed) J. J. Klenner M. D.
(Address) 7145 Boley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

St. Carmel CemeteryNov 14 1922

20 UNDERTAKER

H. Sander & Sons

ADDRESS

1710 E. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69162

CERTIFICATE OF DEATH.

D69162

1-PLACE OF DEATH *1916 Weaver St. - Lonsdale*

REGISTERED NO.

CITY OF BALTIMORE: (No. *2515 Salem St*)ST. *13* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Friedrika Krahn*(a) RESIDENCE. NO. *2515 Salem St*

ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *50* yrs. mos. ds.How long in U. S., if of foreign birth? *50* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Paul Krahn*6 DATE OF BIRTH (month, day, and year) *5/15 1852*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *70*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*10 NAME OF FATHER *John Sweetzer*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*14 Informant (Address) *Mrs Thomas Coleman 2515 Salem St*15 Filed *NOV 14 1922* *ROBERT R. KRAUTER, Registrar**Sanitary Permit Clerk*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 10, 1922*17 I HEREBY CERTIFY, That I attended deceased from *July 1, 1922* to *Nov. 10, 1922* that I last saw her alive on *November 10, 1922* and that death occurred, on the date stated above, at *10 P* m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *2515 Salem St*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Eggs. Sputum 7/10/22*(Signed) *John D. Quinn, M. D.*Address *1507 N. Fulton Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Western Cemetery**11/14 1922*

20 UNDERTAKER

ADDRESS

*George J. Ruth**1735 Harford Ave*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69163

CERTIFICATE OF DEATH.

38
REGISTERED NO.

D69163

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 Sarah Ann ST., 18 WARD)

2-FULL NAME Irene Myers

(a) RESIDENCE No. 1002 Sarah Ann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Blk 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard E. Myers

6 DATE OF BIRTH (month, day, and year) Jan 2, 1900

7 AGE Years 22 Months 10 Days 9 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Lura Thompson

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Howard E. Myers (Address) 1002 Sarah Ann

15 Filed NOV 14 1922 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11/11 1922

17 I HEREBY CERTIFY, That I attended deceased from 7:00 PM 1922, to Nov 11th 1922, that I last saw him alive on Nov 10th 1922,

and that death occurred, on the date stated above, at 9:50 a m. The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Convulsions & Coma (duration) yrs. mos 2 ds.

18 Where was disease contracted

if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Gustav Goldman M. D.

, 19 (Address) 616 W. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER Mrs. A. Easton 14 1922 ADDRESS 916

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement: it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Probably Luetic

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69164

CERTIFICATE OF DEATH.

D69164

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 1411 E. Eager ST., 10 WARD)

2. FULL NAME

William H. Sherbert

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1411 E Eager

ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? 34 yrs. 8 mos. 26 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

6a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Anna M. Sherbert

6 DATE OF BIRTH (month, day, and year)

February 16, 1888

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

34

8

26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Chaffner

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Thomas Sherbert

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Catherine Lind

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant

(Address)

Mrs. Anna M. Sherbert
1411 E Eager

15

Filed

19

ROBERT R. KRAUTER,
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

November 12, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 22, 1922, to Nov. 12, 1922

that I last saw him alive on Nov. 11, 1922

and that death occurred, on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Sarcoma

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary)

Intestinal Tuberculosis

(duration) — yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) E. J. Sebel M. D., M. D.

19 (Address) 1001 Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Holy Redeemer Cemetery

Nov. 15, 1922
Henry Hock Sow 1301 Eager St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D69165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2618 E Preston ST.,WARD) 8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Francis J. Bory(a) RESIDENCE No. 2618 E. Preston ST.,

WARD

(Usual place of abode)

(If non-resident, give city or town and State)

Length of residence in city or town where death occurred

yrs. 11 mos. 15 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 Single, Married, Widowed,
or Divorced, (write the word)Single5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

November 28 1921

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.1115

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workNone(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Balto. Md.

10 NAME OF FATHER

John V. Bory11 BIRTHPLACE OF FATHER (city or town)
(State or country)Balto. Md.

12 MAIDEN NAME OF MOTHER

Wilhelmina Frank13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Balto. Md.

14

Informant
(Address)Mr. John V. Bory
2618 E. Preston

15

Filed

NOV 14 1922ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

November 13 1922

17

I HEREBY CERTIFY That I attended deceased from

Nov 10, 1922 to Nov 13, 1922.that I last saw him alive on Nov 13, 1922.and that death occurred, on the date stated above, at 11 AM m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Acute Congestive Type
(duration) yrs. mos. ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

Physical Signs(Signed) Dr. H. E. Barker, M. D.(Address) 1114 HagermanState the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

Holy Redeemer CemeteryNov 15 1922

20 UNDERTAKER

ADDRESS

Henry Beck Son1301 E. Eager

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69166

CERTIFICATE OF DEATH.

197 D69166

1-PLACE OF DEATH

City of BALTIMORE: (No. *Mercy Hospital* St. *11* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William C. Ellermeier

(Residence in Baltimore: *1623 Brantly St.* St. *15* yrs. *12* mos. *12* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH. *Sept 18 1854*
(Month) (Day) (Year)

7-AGE. *68* yrs. *12* mos. *12* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. *Cliff*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE.

(State or Country). *Balt*

10-NAME OF FATHER. *Charles Ellermeier*

11-BIRTHPLACE OF FATHER. *Germany*
(State or Country)

12-MAIDEN NAME OF MOTHER. *Elizabeth Cooper*

13-BIRTHPLACE OF MOTHER. *N.C.*
(State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Virginia Ellermeier*
(Address) *3021 Wm. Don Ln.*

NOV 14 1922 ROBERT R. KRAUTER,
Filed 1922 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. *Nov 12 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest, autopsy or inquiry, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Disturbance of heart, probably homicidal, American Express.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) *Wm. C. Ellermeier* M. D. (Coroner.)
Nov 12 1922 (Address) *1623 Brantly*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Boarding Houses) At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. *Baltimore Cem.* DATE OF BURIAL. *11/18/22*

20-UNDERTAKER. *Wm. J. Smith* ADDRESS. *1532 Hollins St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69168

CERTIFICATE OF DEATH.

D69168

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3051 Fredericks Ave. ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Minnie Bayer

(a) RESIDENCE. NO. 3051 Fredericks Ave. ST. 20 WARD. Life

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced (write the word) widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Bayer

6 DATE OF BIRTH (month, day, and year) Feb. 9, 1854

7 AGE Years 68 Months 9 Days 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

10 NAME OF FATHER John Amrhein

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Louis Bayer (Address) 3531 Old Fredk. Road.

15 Filed NOV 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

July 9, 1922 to Nov 12, 1922 that I last saw her alive on Nov 12, 1922

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Right Breast

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Asa L. Wessels, M. D.

11-13, 1922 (Address) 2565 Fredericks Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Baltimore Cemetery Nov. 15, 1922

20 UNDERTAKER

E. W. Dill

ADDRESS 3109

Fredk. Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

State of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE
D69169 100-001 D69169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. *John Hopkins* St. *10* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *Le Roy Brown*
(Residence in Baltimore: No. *1244 E Monument* St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Male</i>	4-COLOR OR RACE <i>Black</i>	5-Single, Married, Widowed, or Divorced. <i>Widowed</i> (Write the word.)
6-DATE OF BIRTH. (Month) (Day) (Year)		
7-AGE. yrs. <i>11</i> mos. ds. If LESS than 1 day, hrs. or min.?		
8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country).		
PARENTS.	10-NAME OF FATHER.	
	11-BIRTHPLACE OF FATHER. (State or Country).	
	12-MAIDEN NAME OF MOTHER.	
	13-BIRTHPLACE OF MOTHER. (State or Country).	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant).
(Address).

15-*NOV 14 1922* *ROBERT R. KRAUTER*
Filed 1922
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) (Day) (Year)	<i>Nov 7 1922</i>
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an <i>inquest</i> (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said <i>inquest</i> (Inquest, autopsy or inquiry.) find that said deceased came to <i>death</i> on the day stated above. The CAUSE OF DEATH* was as follows: <i>Bornia - pneumonia</i>	
(Duration) yrs. mos. ds.	
CONTRIBUTORY (Secondary) <i>Rachitis</i>	
(Signed) <i>J. S. Diller</i> M. D. (Coroner)	
18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?	
Former or usual residence.	
19-PLACE OF BURIAL OR REMOVAL, <i>HOPKINS HOSPITAL</i>	DATE OF BURIAL, <i>NOV 15 1922</i>
20-UNDERTAKER,	ADDRESS

19659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)2-FULL NAME Michael Handschuh(a) RESIDENCE NO. Unknown

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds.ST. 76 WARD

WARD

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed,
or Divorced, (write the word) Married5a If married, widowed, or divorced
HUSBAND of Unknown
(or) WIFE of6 DATE OF BIRTH (month, day, and year) 18637 AGE Years Months Days If LESS than
59 -- -- 1 day, hrs
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work Baker(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14

Informant Municipal Hospital Records
(Address)

15

Filed NOV 14 1922 ROBERT H. KRAUTER
Registrar

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 192217 I HEREBY CERTIFY, That I attended deceased from
November 30, 1915 to November 12, 1922.
that I last saw him alive on November 12, 1922.
and that death occurred, on the date stated above, at 9:55 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis(duration) 35 yrs. mos. ds.CONTRIBUTORY (Secondary) Cerebro spinal
Syphilis (duration) 10 yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? NOWhat test confirmed diagnosis? Wasserman
(Signed) Clifford M. Hill M. D.11/13/1922 Address Municipal Hospital*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Interment

DATE OF BURIAL

Nov 15 1922

20 UNDERTAKER

William Cook

ADDRESS

502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4847 Park Hl. Ave. ST.: 27 WARD)2-FULL NAME Lora Cecelia Bell-(a) RESIDENCE. NO. 4847 Park Hl. Ave. ST.: 27 WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 3 mos. 0 ds.How long in U. S., if of foreign birth? 5 yrs. 3 mos. 0 ds.

(If nonresident give city or town and State)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced (write the word) Single5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____6 DATE OF BIRTH (month, day, and year) April 15 1887

7 AGE

Years 45Months 6Days 29If LESS than 1 day, hrs. _____ or min. _____

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher(b) General nature of industry, business, or establishment in which employed (or employer) _____(c) Name of employer _____9 BIRTHPLACE (city or town) Hoffmanville, Md. (State or country)10 NAME OF FATHER J. Jarey Bell11 BIRTHPLACE OF FATHER (city or town) _____ (State or country)12 MAIDEN NAME OF MOTHER Catherine Hoffman13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country)

14

Informant Mary C. Bell (Address) 4847 Park Hl. Ave.

15

Filed NOV 14 1922

19

Burial Permit Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 1922, to Nov 12, 1922, that I last saw him alive on Nov 12, 1922.and that death occurred, on the date stated above, at 8:30 A.

The CAUSE OF DEATH* was as follows:

Acute myocarditis(duration) 5 yrs. 5 mos. 5 ds.CONTRIBUTORY (Secondary) Dementia Tracox(duration) 12 yrs. 12 mos. 12 ds.15 Where was disease contracted if not at place of death? _____Did an operation precede death? _____ Date of _____Was there an autopsy? _____What test confirmed diagnosis? _____(Signed) John J. Bueck M. D.19 (Address) 4847 Park Hl. Ave.

*State the Disease Causing Death, or in death from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Alexia Md. Nov 15 1922

20 UNDERTAKER

ADDRESS

Wm Cork 502 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Volunteers of America Hospital* ST. *18* WARD)

REGISTERED NO. *129 180172*

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Albert M. Mount*

(a) RESIDENCE. NO. *854 W. Fayette St.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *15* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Bertha Mount

6 DATE OF BIRTH (month, day, and year) *Sept 18 1887*

7 AGE Years *64* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Howard Co Md* (State or country)

10 NAME OF FATHER *Un/known*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Un/known*

12 MAIDEN NAME OF MOTHER *Susanna Mathews*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md.*

14 Informant *Lillian Nichols* (Address) *Laurel Md.*

15 Filed *NOV 14 1922* 19 *ROBERT H. KRAUTER, Registrar* Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 13 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Sept 24 1922* to *Nov 13 1922* that I last saw him alive on *Nov 13 1922* and that death occurred, on the date stated above, at *2 a.* m. The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) *5* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Uremia (duration) *2* yrs. *8* mos. *10* ds.

18 Where was disease contracted if not at place of death? *?*

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *Albumen test*

(Signed) *Albert J. Conway*, M. D.

, 19 (Address) *Vol. of Am. Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laurel Md. *Nov 15 1922*

20 UNDERTAKER

ADDRESS

Wm Cook 302 E North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

069173

069173

129

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 Bishop Rd. ST. 12 WARD

2-FULL NAME

Clice Maude Gaither

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

Georgetown apt 4

ST. _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

H. E. Gaither

6 DATE OF BIRTH (month, day, and year)

Feb 1863

7 AGE

59 Years

9 Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Richmond Va

10 NAME OF FATHER

Robert H. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Richmond Virginia

12 MAIDEN NAME OF MOTHER

Clara Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Bachman Ind

14

Informant (Address)

Ernest Gaither Bishop Rd

15

Filed

276171 MON ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 16, 19 22, to Nov 12, 19 22.

that I last saw her alive on Nov 12, 19 22

and that death occurred, on the date stated above, at 3 A in.

The CAUSE OF DEATH* was as follows:

5-12 PM
Valvular Disease of the Heart

(duration) 5 yrs. mos. ds.
CONTRIBUTORY hypertension & High B. P.
(Secondary)

(duration) 2 yrs. mos. ds.
18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr. J. J. G. G., M. D.

11/14/22, 19 (Address) 117 N. Davidson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Druid Ridge Cem

20 UNDERTAKER

Wm J. Hickman

DATE OF BURIAL

11/14/22

ADDRESS

117 N. Davidson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

269174

269174

CERTIFICATE OF DEATH.

101-001

269174

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 573 Hargrove ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward Smith

(a) RESIDENCE. NO.

573 Hargrove ST. 11 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 16 mos. 16 ds. How long in U. S., if of foreign birth? 16 yrs. 16 mos. 16 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of Sumner Smith (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25-1867

7 AGE Years 54 Months 10 Days 16 If LESS than 1 day, 16 hrs. or 16 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (b) General nature of industry, business, or establishment in which employed (or employer) Paper factory (c) Name of employer Oregon Paper factory

9 BIRTHPLACE (city or town) Va (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14

Informant Eleanor Jones (Address) 210 W. Chestnut St

15

Filed NOV 14 1922 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov - 11 1922

17 I HEREBY CERTIFY. That I attended deceased from Nov 9th 1922 to Nov 11th 1922 that I last saw him alive on Nov 10th 1922 and that death occurred, on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. 2 ds.

18 Where was disease contracted if not at place of death? Y

Did an operation precede death No Date of No

Was there an autopsy? No

What test confirmed diagnosis Regular (Signed) J. C. Smith M. D.

(Address) 1313 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Laural Cemetery

Nov 15 1922

20 UNDERTAKER

ADDRESS 1723

Mrs Robert A. Elliott

Ashland

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec. 1-10-21 M&T 1800 Bks.

D69175

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69175
129 ✓

1-PLACE OF DEATH

Municipal Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10)

ST.,

WARD)

2-FULL NAME

Daniel Carter

(a) RESIDENCE NO. 1105 Ashland Ave

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Samuel Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore

12 MAIDEN NAME OF MOTHER

Ellen Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Ray Kender

15

Filed

NOV 14 1922

ROBERT R. KRAUTER,

Bureau Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

11-11-1922

17

I HEREBY CERTIFY, That I attended deceased from

9-8-1922 to 11-11-1922

that I last saw him alive on 11-11-22, 1922

and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration)

yrs.

mos.

ds.

CONTRIBUTORY (Secondary)

Myocardial Infarction

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed)

Chas. M. M. M.

M. D.

11-12-1922 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Laurel Cemetery

DATE OF BURIAL

Nov 18 1922

20 UNDERTAKER

Mrs Robert A. Elliott

ADDRESS

125 Ashland

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 N. Caroline ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 717 N. Caroline St St.; 0 yrs., 0 mos., 0 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

F

4-COLOR OR RACE,

C

5-SINGLE, Single
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

Jan 3, 1918
(Month) (Day) (Year)

7-AGE,

4 yrs., 10 mos., 8 ds.
If LESS than 1 day,
...hrs. or...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE,
(State or Country),Balto Md.

10-NAME OF FATHER,

Joseph Thompson11-BIRTHPLACE OF FATHER
(State or Country),Balto Md.

12-MAIDEN NAME OF MOTHER

Annie Williams13-BIRTHPLACE OF MOTHER
(State or Country),Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE,

(Informant) Annie Thompson (Mother)(Address) 717 N. Caroline St

15-

Filed NOV 14 1922 191... ROBERT R. KRAUTER,
Burial Permit Refused

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov. 19, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from
Nov. 8 1922, to Nov 11 1922,that I saw h in alive on Nov. 10 1922,
and that death occurred, on the date stated above, at 7:40 p. m.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia(Duration) 3 yrs., 0 mos., 0 ds.CONTRIBUTORY Hydrocephalus and
(Secondary) Syphilis(Duration) 4 yrs., 0 mos., 0 ds.(Signed) R. J. Young M. D.

1622 E. Monument St. (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs., 0 mos., 0 ds. In the State 0 yrs., 0 mos., 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL.

My-Aurora CoNov. 14, 1922

20-UNDERTAKER

ADDRESS

Mr Robert A Elliott1725 Ashland Ave

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

269177

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 710 Spring ST.; 10 WARD)

2-FULL NAME

Arlene Carter

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 710 Spring ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

6a If married, widowed, or divorced

(or) WIFE of

Wm H Carter

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Annapolis

10 NAME OF FATHER

James Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Annapolis

12 MAIDEN NAME OF MOTHER

Martha Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Annapolis

14

Informant (Address)

John Carter 710 N Spring St

15

Filed

19

ROBERT A. KRAUTER

Registrar

NOV 14 1922

Social Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 11 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 15, 1922, to Nov 11, 1922

that I last saw him alive on Nov 11, 1922

and that death occurred, on the date stated above, at 145 P. M.

The CAUSE OF DEATH* was as follows:

Old Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of.

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

H. W. White Jr. M. D.

, 19 (Address)

2800 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt-Arthur Co

Nov 14 1922

20 UNDERTAKER

ADDRESS

Mrs Robert A Elliott

1725 Ashland St

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69178

CERTIFICATE OF DEATH.

31 D69178

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2105 Sassafras St ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Pearl S. Blocher

(a) RESIDENCE. NO.

7105 Sassafras

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

14 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Mar. 7, 1902

7 AGE

Years

Months

Days

If LESS than

1 day, hrs.

or min.

20

8

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore, Md.

10 NAME OF FATHER

Jackson Blocher

11 BIRTHPLACE OF FATHER (city or town) (State or country)

N. C.

12 MAIDEN NAME OF MOTHER

Carrie Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

N. C.

14

Informant (Address)

Jackson Blocher 2105 Sassafras St.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from

May 1st, 1922, to Nov. 10, 1922

that I last saw her alive on Nov. 10, 1922

and that death occurred, on the date stated above, at 5:45 P. M.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

Exhaustion

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. J. Hughes M. D.

Address 443 E. Hill St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Mt. Auburn Cemetery Nov. 15, 1922

20 UNDERTAKER

ADDRESS

Samuel Kennedy 57 E. Hill St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PHYSICIANS should state EXACTLY. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2020 Curran ST. 14 WARD)2-FULL NAME Francina Matthews(Residence in Baltimore: No. 2120 Curran St.; yrs., mos. 10 ds.)REGISTERED NO. C. 40 862179

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single6-DATE OF BIRTH, Nov 1, 1922
(Month) (Day) (Year)7-AGE, 10 yrs., mos. 10 ds. If LESS than 1 day,hrs. ormin.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None9-BIRTHPLACE, (State or Country), Baltimore10-NAME OF FATHER, Harmon Brown11-BIRTHPLACE OF FATHER (State or Country), MD12-MAIDEN NAME OF MOTHER Georgis Matthews13-BIRTHPLACE OF MOTHER (State or Country), MD

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henrietta Matthews(Address) 2120 Curran St

15-

Filed NOV 14 1922 191. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Nov 9 1922, to Nov 11 1922, that I saw her alive on Nov 11 1922, and that death occurred, on the date stated above, at 6:30 P m. The CAUSE OF DEATH* was as follows:Infection of nasal and eye
(Duration)yrs.mos. 5 ds.CONTRIBUTORY (Secondary) Bereavement(Signed) Fred C. Jewell M. D.
Nov 11, 1922 (Address) 2516 Penn. Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of deathyrs.mos.ds. In the Stateyrs.mos.ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, At Auburn DATE OF BURIAL, 11/11/2220-UNDERTAKER Sam'l Housley ADDRESS 578

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2496 Buchanan ST. 17 WARD)

2-FULL NAME

(a) RESIDENCE. No. 2406 Buchanan ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE OL 5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18477 AGE Years 75 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond Va (State or country)10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown14 Informant Thos D. Douglass (Address) 2406 Buchanan St15 Filed NOV 14 1922

ROBERT R. KRASNER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 192217 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1922 to Nov 11, 1922, that I last saw him alive on Nov 11, 1922, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease
(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Physicil Ex -
(Signed) R. G. Galt M. D.Nov 14 1922 Address 1534 - 20th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS 578Paul T. Hecker Middle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

STATE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D62181

CERTIFICATE OF DEATH.

874-001

D62181

1-PLACE OF DEATH

Pronounced dead at

Registered No. C.....

City of BALTIMORE: (No. St., Ward)

St. Joseph's Hosp.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

William A. Hamill

(Residence in Baltimore: No. St., yrs. mos. ds.)

1105 N. Bradford

St., yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Black

5-Single, Married, Widowed, or Divorced. (Write the word.)

Married

6-DATE OF BIRTH

March

31

1898

(Month)

(Day)

(Year)

7-AGE

64

yrs.

7

mos.

12

ds.

If LESS than 1 day,

.... hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

Structural

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE

(State or Country)

Balto., Md.

10-NAME OF FATHER

Wm. A. Hamill

11-BIRTHPLACE OF FATHER

(State or Country)

England

12-MAIDEN NAME OF MOTHER

Eloise Hutton

13-BIRTHPLACE OF MOTHER

(State or Country)

Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Wm. M. P. P. P.

(Address)

45 Pennington Ave.

15-

Filed

NOV 14 1922

ROBERT R. KRAUTER

Bureau of Health

Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Nov

12

1922

(Month)

(Day)

(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, au-

topsy or inquiry, and that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably - Cerebral Hemorrhage

apoplexy

First paralytic stroke 3 yrs ago

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Alcoholism

(Duration) yrs. mos. ds.

(Signed) J. H. Satter

(Coroner)

11-13 1922 (Address) 508 E. Pratt St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

David Ridge

Nov. 14, 1922

20-UNDERTAKER

Jirkler & Jirkler

ADDRESS

1739 Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1200 Fairview Co. E. 34th* ST. *40* WARD)2-FULL NAME *Mary Matosec*(a) RESIDENCE. No. *1200 Fairview* ST. *40* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred *19* yrs. *1* mos. *1* ds.How long in U. S., if of foreign birth? *19* yrs. *1* mos. *1* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female*4 COLOR OR RACE *White*5 Single, Married, Widowed, or Divorced (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Stephen Matosec*6 DATE OF BIRTH (month, day, and year) *Jul 25 1903*

7 AGE

Years *19*Months *7*

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housewife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Bohemia*10 NAME OF FATHER *Rudolph Yurak*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Bohemia*12 MAIDEN NAME OF MOTHER *Mary Panek*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Bohemia*

14

Informant (Address) *Stephen Matosec 1200 Fairview Co. E. 34th St. 40 W.*

15

Filed *14 1922*

ROBERT H. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 13* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

Jan 17, 19*20*, to *Nov 13*, 19*22*.that I last saw him alive on *Nov 12*, 19*22*.and that death occurred, on the date stated above, at *11:30 a.m.*

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis(duration) *3* yrs. *1* mos. *—* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of *—*Was there an autopsy? *no*What test confirmed diagnosis? *Bacteriological*(Signed) *Edward J. Moran*, M. D.19 (Address) *811 N. Paul St. av.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Holy Cross**Nov 15* 19*22*

20 UNDERTAKER

ADDRESS

Frank Evans Son 1906 K. St. av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69183

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D69183

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

ST.

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

Str.; 30 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word)

6-DATE OF BIRTH Not known, 1 (Month) (Day) (Year)

7-AGE 30 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Balto.

10-NAME OF FATHER James Mizerowsky

11-BIRTHPLACE OF FATHER (State or country) Bohemia

12-MAIDEN NAME OF MOTHER Anna Kulhaneh

13-BIRTHPLACE OF MOTHER (State or country) Bohemia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

NOV 14 1922

ROBERT R. KRAUTER,

Burial Permit

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from

May 1, 1912, to Nov 11, 1922

that I saw him alive on Nov 11, 1922

and that death occurred, on the date stated above, at 5:45 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, Duodenal

Contributory (SECONDARY)

(Duration) yrs. 12 mos. ds.

(Signed) William H. Brown, M.D.

(Address) 14 N. Carroll

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted?

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Oak Hill

Nov. 14, 1922

20-UNDERTAKER

ADDRESS

Frank E. Coe, Jr.

1906 Highland

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)2-FULL NAME Jane Register(a) RESIDENCE NO. Unknown

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

ST., 76 WARD

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced, (write the word)
Widowed5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Domestic

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Ireland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Unknown

14

Informant
(Address)Hospital Records,
Municipal Hospital.

15

Filed

ROBERT R. KRAUTER,

Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 12 19 22

17

I HEREBY CERTIFY, That I attended deceased from
November 1, 19 22, to November 12, 19 22.that I last saw her alive on November 12, 19 22.and that death occurred, on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritisCONTRIBUTORY
(Secondary)18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of.

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

11/13/22 (Address) Municipal Hospital.*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

St. Johns Cemetery

20 UNDERTAKER

Thos. M. Jones - Frank

DATE OF BURIAL

11/14 19 22

ADDRESS

1737 W. Pratt St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

169185
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 17088 Charles ST. 23 WARD)

2-FULL NAME William A. McCommons

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1708 S Charles ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Virginia McCommons

6 DATE OF BIRTH (month, day, and year) Jan 7, 1854

7 AGE Years Months Days If LESS than 1 day, hrs or min. 68 10 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Hartford Ct. Mich

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Unknown

14

Informant (Address)

Virginia McCommons 1708 S Charles

15

Filed

NOV 14 1922

ROBERT R. KRAUTER,

Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 11 1922

17 I HEREBY CERTIFY, That I attended deceased from Mar 11, 1922, to Mar 14, 1922.

that I last saw him live on Mar 10, 1922.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Arterio Sclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinal

(Signed) J. F. Harrison, M. D.

12022 Address 1 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Baltimore Cemetery

DATE OF BURIAL

Mar 14 1922

20 UNDERTAKER

E. J. Downing & Son - 1460 Battery Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-**0691886** BATHCITY OF BALTIMORE: (No. 1913 Esquith ST.; 9 WARD)2-FULL NAME Samuel H. Giles(Residence in Baltimore: No. 1913 Esquith St.; 2 yrs., 7 mos., 7 ds.)90 **869186**
REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male 4-COLOR OR RACE. colored 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. Married
(Write the word.)6-DATE OF BIRTH, July 7, 1865
(Month) (Day) (Year)7-AGE, 57 yrs., 4 mos., 4 ds. If LESS than 1 day, hrs. or min.?8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Driver
(b) General nature of industry, business, or establishment in which employed (or employer).9-BIRTHPLACE, (State or Country), Maryland10-NAME OF FATHER, Samuel Giles11-BIRTHPLACE OF FATHER (State or Country), Maryland12-MAIDEN NAME OF MOTHER not known13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Orpha. Giles(Address) 1913 Esquith15-
Filed..... 191.....

NOV 14 1922

ROBERT R. WEAVER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 11, 1922
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from SEP 1 3 1922 191, to NOV 1 0 1922 191,that I saw h..... alive on NOV 1 0 1922 191,and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilated Heart(Duration)..... yrs. 2 mos. 7 ds.CONTRIBUTORY (Secondary) Chronic Endocarditis(Duration)..... yrs. 7 mos. 7 ds.(Signed)..... J. H. Dukes M. D.NOV 1 3 1922 (Address) 928 E. North St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Asbury Lane DATE OF BURIAL, Nov 14, 192220-UNDERTAKER Dr. M. H. Clark ADDRESS 2007 Market

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

D69187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 31

D69187

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME JOSE LEYESA ROXAS

(a) RESIDENCE NO. 2650-Maryland-Ave.

(Usual place of abode)

ST., 12

WARD

Philippine Islands

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 4 mos. ? ds. How long in U. S., if of foreign birth? 0 yrs. 5 mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Male Filipino Single

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year) December-2-1903

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
18 11 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student at the

(b) General nature of industry, business, or establishment in which employed (or employer) Johns Hopkins

(c) Name of employer University

9 BIRTHPLACE (city or town) Lipa
(State or country) Philippine Islands.

10 NAME OF FATHER Sixto Roxas

11 BIRTHPLACE OF FATHER (city or town) Lipa
(State or country) Philippine Islands.

12 MAIDEN NAME OF MOTHER Lucila Leyesa

13 BIRTHPLACE OF MOTHER (city or town) Lipa
(State or country) Philippine Islands14 Informant Bienvenido Gonzalez (friend)
(Address) 2136-Oak-St., Baltimore.

15 Filed NOV 14 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 10, 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1922, to Nov. 10, 1922.

that I last saw him alive on Nov. 10, 1922,

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY Pulmonary Tuberculosis
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P.S. & S.

(Signed) John J. Krieger, M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Lipa-via Manila-Philippine Islands. about Nov-22-22

20 UNDERTAKER ADDRESS

STEWART & MOWEN COMPANY

(J. F. WOODEN, Successor)

108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. E
TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M & T - 1500 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 Calloway ST., 13 WARD)

2-FULL NAME

Jennie Cohen

(a) RESIDENCE NO.

2402 Calloway ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds.

How long in U. S., if of foreign birth? 29 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Joseph Cohen

6 DATE OF BIRTH (month, day, and year)

1861

7 AGE

61

Years

Months

Days

If LESS than
1 day, hrs.
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Russia

10 NAME OF FATHER

Morris Leshman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Russia

12 MAIDEN NAME OF MOTHER

Barth Leshman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Russia

14

Informant
(Address)

Jack Lewis
1439 E. Bait Street

15

Filed

19

ROBERT R. KRAUTER
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Jan, 1920, to Nov, 1922,

that I last saw him alive on Nov 12, 1922,

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Diabetes mellitus

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? albuminuria sept/mo 270

(Signed) Harry Adler, M. D.

, 19 (Address) 174 Cedar Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Whelem French Ship 11/14 1922
Jack Lewis 1439 E. Bait St

CAUSE OF DEATH in plain terms, so that it may be properly classified. **Exact statement of OCCUPATION** is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T -
J69189

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 69189

160459

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *Hamwood Hospital*

REGISTERED NO

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. November 13-1922 ST. 1 WARD)

2-FULL NAME Mrs. Blanch Keeble

(a) RESIDENCE NO. 832 N. Guntaw St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
-------	-----------------	--

Female white married

5a If married, widowed, or divorced
HUSBAND of Dr. Henry H. Keech.
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 3 - 1867*

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or min.
	55	✓	10	

• OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bel-Air - Hayford Co.
(State or country)

10 NAME OF FATHER *Dr. Richard Lee*

11 BIRTHPLACE OF FATHER (city or town) Harford Co
(State or country) md

12 MAIDEN NAME OF MOTHER *Mary Moore*

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Miss. Gove
(Address) 534 M. St.

15 Filed NOV 14 1922 ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar. 13* 19 *22*

17 I HEREBY CERTIFY, That I attended deceased from
Nov. 3, 1922, to Nov. 13, 1922,
that I last saw her alive on Nov. 12, 1922,
and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(duration) yrs. mos. ds

CONTRIBUTORY Abdominal Effusion
(Secondary)

(duration) yrs. mos. ds

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of Nov 4/22

Was there an autopsy? No.

What test confirmed diagnosis? Chemical symptoms
 Patient has had normal temperature & pulse
 (Signed) Chemical laboratory M. D.
 symptoms Stitches removed Nov 11/22
 19 (Address) 812 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL	DATE OF BURIAL
---	----------------

20 UNDERTAKER	ADDRESS
---------------	---------

Mr. M. Garthoff 2839 Ray

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 1-10-21 M&T 1500 Hks.

869190 HEALTH DEPARTMENT—CITY OF BALTIMORE 869190
90-162150

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 76 WARD)

2. FULL NAME Adolphus White

(a) RESIDENCE NO. Unknown

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 56 -- --

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records,

(Address) Municipal Hospital.

15 Filed 37617-1 MON 19 ROBERT R. KRAUTER Registrar

1966

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11 19 22

17

I HEREBY CERTIFY, That I attended deceased from November 9, 19 22 to November 11 19 22. that I last saw him alive on November 10 19 22. and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Clyde E. Hines M. D.

11/13/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

Commissioner Health.

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: NO.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

The CAUSE OF DEATH was as follows:

1. Strangulated Inguinal Hernia
2. Intestinal Obstruction

CONTRIBUTORY (Secondary)

18 Where was disease contracted
If not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. A. Wilson, M. D.

(Address) Med. San. Hospital

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

NOV 14 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

Harry H. Witzke 1531 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

10.69192

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.69192

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Community Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

ST.:

WARD)

2-FULL NAME

William H. Barnhart

(a) RESIDENCE. No.

2127. Woodbury Ave.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2. mos.

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Fannie May Barnhart

6 DATE OF BIRTH (month, day, and year)

Sept 12, 1856

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

66

2

—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labour.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Baltimore Md.

10 NAME OF FATHER

Mr. H. Barnhart.

11 BIRTHPLACE OF FATHER (city or town)

Md.

(State or country)

12 MAIDEN NAME OF MOTHER

Charlotte Price.

13 BIRTHPLACE OF MOTHER (city or town)

Md.

(State or country)

14

Informant
(Address)Miss Mollie Barnhart.
3406. Duane St.

15

Filed

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 11 1922 to Nov 12 1922

that I last saw him live on Nov 12 1922

and that death occurred, on the date stated above, at 8⁴⁵ P.m.

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY
(Secondary)

Carcinoma colon

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Physical signs

(Signed)

J. H. Jones M. D.

4/12/22 (Address)

Community Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

St. Mary's (Hamden)

Nov. 16 1922

20 UNDERTAKER

ADDRESS

Horace H. Burgee

363 Falls Rd.

D. 69193 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 69193

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 160 N. Curley. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

10 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Peter Zink

6 DATE OF BIRTH (month, day, and year)

1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

60

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

James Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Virginia

14

Informant (Address)

Anna Mowbray 904 Hancock St.

15

Filed

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 12 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1922, to Nov. 12, 1922.

that I last saw him alive on Nov. 12, 1922.

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

P. H. Hermann, M. D.

(Address)

7919 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER

DATE OF BURIAL

ADDRESS

Holy Redeemer Am.

Lilly End Zeiler

Nov 15 1922

403 S. M. St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3717 Eastern Ave. ST., 26 WARD)

2-FULL NAME

(a) RESIDENCE NO. 3717 Eastern Ave. ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 1 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

7 12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore City

10 NAME OF FATHER

Bernhard Hartman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore City

12 MAIDEN NAME OF MOTHER

Margaret Hogg

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore City

14

Informant (Address)

Bernhard Hartman
3717 Eastern Ave.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 19 22

17

I HEREBY CERTIFY, That I attended deceased from 11/7/22, 19 22, to 11/12, 19 22, that I last saw him alive on 11/12/22, 19 22, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Ills colitis

CONTRIBUTORY (Secondary)

(duration)

yrs. 2 mos. ds.

(duration)

yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

11/14/22 Address)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

MOVAL

Sacred Heart Cem.Nov. 15 1922

20 UNDERTAKER

ADDRESS

Lilly and Zeller403 S. W. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 S. Bouldin ST. 76 WARD)2-FULL NAME Clement J. Martel(a) RESIDENCE NO. 928 S. Bouldin ST. 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 6 - 19227 AGE Years Months Days If LESS than 1 day, hrs. or min. 1 8

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) City10 NAME OF FATHER Clement Martel11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) City12 MAIDEN NAME OF MOTHER Pearl Elliott13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)14 Informant Clement J. Martel (Address) 928 S. Bouldin St.15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

10/6, 1922, to 11/13, 1922,that I last saw him alive on 11/12, 1922,and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Spiral Rupture

(duration) yrs. mos. ds.

CONTRIBUTORY acute myocarditis

(Secondary)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

J. M. Carroll M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Sacred Heart Cem

20 UNDERTAKER

Lilly and Zule

DATE OF BURIAL

Nov 15 1922

ADDRESS

403 S. W. 1st St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D. 69196

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 69196

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *161-001*)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

WARD.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day 9 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-14-1922

17

I HEREBY CERTIFY, That I attended deceased from

11-13-1922, to 11-14-1922

that I last saw him alive on 11-13-1922

and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth 6 months fetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James D. Schermer, M. D.

(Address) 4012 Park St. N. W.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER

Commissioner Health

ADDRESS

NOV 1 1922

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

10.69197

HEALTH DEPARTMENT—CITY OF BALTIMORE

10.69197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4152 Pennlio Rd St.; 15 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Parthenia Sewell Parrano (PASSANO)

(Residence in Baltimore: No. 4152 Pennlio Rd St.; 15 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F 4-COLOR OR RACE, W 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH Feb 15, 1841 (Month) (Day) (Year)

7-AGE, 80 yrs., 8 mos., 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Baltimore

10-NAME OF FATHER, James Crawford

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Charlotte Cromwell

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Joseph Passano

(Address), 4152 Pennlio Rd

15-

Robert P. Harrison, Jr.

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 12, 1922, to Nov 12, 1922, that I saw h. alive on Nov 12, 1922, and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast (Duration) 14 yrs., 14 mos., ds.

CONTRIBUTORY (Secondary)

(Signed) Fred L. Jewett M. D. (Address) 2516 Pennlio Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, 11/16/22

20-UNDERTAKER, Address, John E. Frank 100 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PHYSICIANS should be stated EXACTLY. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 69198

74 D 69198

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2006 Portugal ST., 2 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Withowski

(a) RESIDENCE No 2006 Portugal (Usual place of abode)

ST., WARD

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 4 COLOR OR RACE 5 Single, Married, Widowed, or Divorced, (write the word)

Female white Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Steve Withowski

6 DATE OF BIRTH (month, day, and year) July 7 1863

7 AGE Years Months Days If LESS than 1 day, hrs or min. 59 4 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Balcer Cichocki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Jolanna Withowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Tekla Cieszarzakh (Address) 251 S Washington

15 Filed 19 Robert P. Harrison Registrar

NOV 14 1922

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 19 22

17 I HEREBY CERTIFY, That I attended deceased from Nov 5, 19 22, to Nov 12, 19 22.

that I last saw her alive on Nov 11, 19 22,

and that death occurred, on the date stated above, at 850 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

7 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) Daniel S. Fisher, M. D.

, 19 22 (Address) 5325 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL DATE OF BURIAL

Holy Rosary Nov 15 19 22

20 UNDERTAKER ADDRESS

John A. Weber 1803 Bank

20.69199

HEALTH DEPARTMENT—CITY OF BALTIMORE

20.69199

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1295 William St.

ST.,

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

C. Gustav Creutzer

(a) RESIDENCE NO. 1295 William St.

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds.

How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Henrietta Creutzer

6 DATE OF BIRTH (month, day, and year) Feb. 25 1841

7 AGE Years 61 Months 8 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired-Dyer and

(b) General nature of industry, business, or establishment in which employed (or employer) Cleaner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER Mr. Creutzer

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany

12 MAIDEN NAME OF MOTHER Miss Kreutzer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant Mrs. Christopher Eitemiller (Address) Catonsville, Md.

15

Robert P. HARTMAN,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1922, to Nov. 13, 1922, that I last saw him alive on Nov. 13, 1922, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic cystitis & enlarged prostate, causing uric acid

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed)

E. R. R. M. D.

11/14 28 (address) 1215 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE

DATE OF BURIAL

Baltimore Cemetery Nov. 16, 1922

20 UNDERTAKER

ADDRESS

Joseph B. Cook 1003 N. Baltimore St.

CAUTION: This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

141922

Partial Permit Given

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 69200

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William T. Lindsey

(a) RESIDENCE NO.

Melrose Ave. Tryon, N.C. ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 week yrs. _____ mos. _____ ds. _____

How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMary E. Lindsey6 DATE OF BIRTH (month, day, and year) Feb 5 - 1865

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.57 9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Fruit-farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Kentucky

10 NAME OF FATHER

John B. Lindsey

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Kentucky

12 MAIDEN NAME OF MOTHER

Helen Talbot

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Kentucky

14

Informant
(Address)JOHNS HOPKINS HOSPITAL

15

Filed

19

Registrar

Robert F. Harrison
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 - 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 6 - 1922, to Nov 13, 1922

that I last saw him alive on

Nov 13, 1922

and that death occurred, on the date stated above, at

4⁰⁵ P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - Hypophyseal
dent tumor(duration) 2 yrs. _____ mos. _____ ds.CONTRIBUTORY
(Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted

if not at place of death?

at home

Did an operation precede death?

Yes Date of Nov. 10 22

Was there an autopsy?

Yes

What test confirmed diagnosis?

Operation

(Signed) ..

J. H. Harrison M. D.

19

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

FRANKFORT KENTUCKY11-14-22

20 UNDERTAKER

ADDRESS

H. E. Hughes424 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

141922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 69201

D. 69201

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

4108 Belle Ave

ST.:

REGISTERED NO. C

WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Seth James Taber

(Residence in Baltimore: No.

4108 Belle Ave

St.; yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE,

White

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word)

Widowed

6-DATE OF BIRTH,

November 2, 1851

(Month)

(Day)

(Year)

7-AGE,

71 yrs. 0 mos. 12 ds.

If LESS than 1 day,

hrs. or min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

Painter

(b) General nature of industry, business, or establishment in which employed (or employer).

Retired

9-BIRTHPLACE,
(State or Country),

Auburn N.Y.

10-NAME OF FATHER,

Seth James Taber

11-BIRTHPLACE OF FATHER
(State or Country),

Not known

12-MAIDEN NAME OF MOTHER

Not known

13-BIRTHPLACE OF MOTHER
(State or Country),

Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Grace M. Campbell

(Address)

4108 Belle Ave

15-

Filed

Robert F. Harrison,

191

Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

November 14th, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

November 13 1922, to Nov. 14th 1922,that I saw him alive on Nov. 13th 1922,

and that death occurred, on the date stated above, at 8 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

Arteriosclerosis

General

(Duration) yrs. mos. ds.

(Signed)

W. H. Brown M. D.

Nov. 14th, 1922 (Address) 1738 Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

Franklinville N.Y.

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Franklinville N.Y.

Nov. 15, 1922

20-UNDERTAKER

ADDRESS

John Burns Sons Towson Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1800 Bks.

DL. 69202

HEALTH DEPARTMENT—CITY OF BALTIMORE

DL. 69202

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. *2127 Washington St., West*)

2. FULL NAME *Magdalena Bealefeld*

(a) RESIDENCE NO. *2127 Washington St., West* WARD

(Usual place of abode) Length of residence in city or town where death occurred *66* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *white* 5 *Single, Married, Widowed, or Divorced* (write the word) *widow*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Frederick H. Bealefeld*

6 DATE OF BIRTH (month, day, and year) *June 16, 1843*

7 AGE Years *79* Months *5* Days *—* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Germany*

10 NAME OF FATHER *Barney Boder*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Germany*

12 MAIDEN NAME OF MOTHER *Marie Boder*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Germany*

14 Informant *John C. Bealefeld* (Address) *2127 Washington St., West*

15 *Robert P. Harrison* 19 *1922*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 13, 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Nov 13, 1922* to *Nov 13, 1922* and that death occurred, on the date stated above, at *11* a. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

CONTRIBUTORY (Secondary) *Internal Hemorrhage* (duration) *2* yrs. *0* mos. *0* ds.

(duration) *no* yrs. *no* mos. *no* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date of *—*

Was there an autopsy? *No*

What test confirmed diagnosis? *urine*

(Signed) *R. V. Glavin*, M. D.

(Address) *1401 N. Calhoun*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Western Cemetery

20 UNDERTAKER

For Joerdens Son

DATE OF BURIAL

Nov 16, 1922

ADDRESS

217 S. Pac

Burial Permit Clerk

D69203

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69203

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Bay View T. B. Hosp 22* ST., *31* WARD)2-FULL NAME *Edward Jennings*(a) RESIDENCE NO. *615 S. Sharp* ST., *4* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? *0* yrs. *0* mos. *0* ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE *26* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Driver*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Maryland*10 NAME OF FATHER *Ed Jennings*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Unknown*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Unknown*

PARENTS

14 Informant *Charles Jennings* (Address) *615 S. Sharp*

15

NOV 15 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 12th 1922*17 I HEREBY CERTIFY, That I attended deceased from *Dec 14*, 19*21*, to *Nov 12*, 19*22*,that I last saw him alive on *Nov 11*, 19*22*and that death occurred, on the date stated above, at *8.0* m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) *1* yrs. *1* mos. *12* ds.

CONTRIBUTORY (Secondary)

(duration) *1* yrs. *1* mos. *12* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *X-Ray & Sputum*(Signed) *Francis L. Bradstreet*, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

St. Mary's Cemetery

20 UNDERTAKER

A. L. Parkman

DATE OF BURIAL

Nov 15 1922

ADDRESS

210 N. Holliday St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Farrish
HEALTH DEPARTMENT—CITY OF BALTIMORE

D69204

CERTIFICATE OF DEATH.

135

D69204

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. *Community Hospital* ST. *11* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Martin Farrish*

(a) RESIDENCE. NO. *1026 Park Ave.* ST. _____ WARD. _____
(Usual place of abode)

Length of residence in city or town where death occurred *25* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Black* 5 Single, Married, Widowed, or Divorced (write the word) *Married*

5a If married, widowed, or divorced
HUSBAND of *Julia Farrish*
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1844*

7 AGE Years *78* Months *1* Days *1* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Butler*
(b) General nature of industry, business, or establishment in which employed (or employer) *Private Butler*
(c) Name of employer *has not worked for years*

9 BIRTHPLACE (city or town) *Murray Co. Tenn.*
(State or country)

10 NAME OF FATHER *Unknown*

11 BIRTHPLACE OF FATHER (city or town) *Unknown*
(State or country)

12 MAIDEN NAME OF MOTHER *Unknown*

13 BIRTHPLACE OF MOTHER (city or town) *Unknown*
(State or country)

14 Informant *Julia Farrish*
(Address) *1026 Park Ave.*

15 Filed *Nov 15 1922* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 14 - 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Nov. 7th*, 1922, to *Nov. 14*, 1922,

that I last saw him alive on *Nov. 14*, 1922,

and that death occurred, on the date stated above, at *1:30 P.M.*

The CAUSE OF DEATH* was as follows:
Uremia
unknown

(duration) yrs. mos. ds.
CONTRIBUTORY *Hypertrophied Prostate with*
(Secondary) *Stomatitis* (duration) *unknown* mos. ds.

18 Where was disease contracted *Unknown*
if not at place of death?

Did an operation precede death? *no* Date of *none*

Was there an autopsy? *No*

What test confirmed diagnosis? *Autopsy*
(Signed) *W. B. Jones*, M. D.

Nov 14 22 (Address) *Community Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL *Milford Station, Va* DATE OF BURIAL *Nov. 17 1922*

20 UNDERTAKER *Bowling Green Co Va* ADDRESS *903*
Edw. W. Page *Edmundson*

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69205

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69205

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1128 Warner

ST.: 21 WARD)

2-FULL NAME

Baby Downing

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. 1128 Warner

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 12 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Maryland

10 NAME OF FATHER Lee Downing

11 BIRTHPLACE OF FATHER (city or town) North Carolina

12 MAIDEN NAME OF MOTHER Rebecca Gross

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Maryland

14

Informant (Address) Rebecca Downing 1128 Warner

15

Filed

NOV 15 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 12 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 12, 1922 to Nov 12, 1922

that I last saw him alive on Nov 12 1922

and that death occurred, on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows:

Abortion (24 hrs)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Prematurity (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. Woodward Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Mt Auburn Ct

DATE OF BURIAL

Nov 15 1922

20 UNDERTAKER

J. L. Brown & Son

ADDRESS

101 W. Montg

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NOV 13 1922) HOPKINS HOSPITAL ST. 21 WARD)

2-FULL NAME

Margaret Miles

(a) RESIDENCE NO.

905 McHenry St.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White

Child

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

March 4-1920

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2

8

9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. Md.

10 NAME OF FATHER

George Miles

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. Md.

12 MAIDEN NAME OF MOTHER

Annie Simons

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informants HOPKINS HOSPITAL (Address)

15

Filed

NOV 15 1922

ROBERT R. KRAUTER, Registrar

Public Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 13 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 9, 1922, to Nov 13, 1922,

that I last saw him alive on Nov 13, 1922,

and that death occurred, on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH* was as follows:

1 Retroperitoneal Sarcoma

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death?

No

Date of

Was there an autopsy?

Yes

What test confirmed diagnosis?

Autopsy

(Signed)

Emile Holmberg, M. D.

, 19 (Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Cathedral Cemetery

Nov 16, 1922

20 UNDERTAKER

ADDRESS

John J. Cawson & Son, 177 Calverton St.

177 Calverton St.

Physician should state exact statement of OCCUPATION is very important. See instructions on back of certificates.

1069207

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 1069207
D69207

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *South Baltimore Gen. Hospital* ST. *20* WARD)

2-FULL NAME

Baby Davis

(a) RESIDENCE NO. *2446 Lauretta Ave.* ST. _____ WARD _____
(Usual place of abode)

Length of residence in city or town where death occurred yrs. _____ mos. _____ ds. _____ How long in U. S., if of foreign birth? yrs. _____ mos. _____ ds. _____
(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *F* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *S*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *Mar 14 1924*

7 AGE Years _____ Months _____ Days _____ If LESS than 1 day, _____ hrs. or 1/2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) *Ind*

10 NAME OF FATHER *Norm C Davis*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *England*

12 MAIDEN NAME OF MOTHER *Nellie Sheppard*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *England*

14 Informant (Address) _____

15 *ROBERT R. KRAUTER, Registrar*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 14 1922*

17

I HEREBY CERTIFY, That I attended deceased from *November 14, 1922* to *November 14, 1922*, that I last saw him alive on *November 14, 1922*, and that death occurred, on the date stated above, at *10:25 a.m.*

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) *Wm. O'Connor*, M. D.

, 19 (Address) *South Baltimore Gen. Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

19

20 UNDERTAKER

ADDRESS

Commissioner Health

NOV 15 1922

Every item of information should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D62238

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. *Sydenham Hospital* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Charles H. Martin

(Residence in Baltimore: No. *1902 W. Lombard St.* St.; yrs. *36* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Male

4-COLOR OR RACE.

White

5-Single, Married, Widowed, or Divorced. (Write the word.) *Married*

6-DATE OF BIRTH.

Dec 12 18*78*
(Month) (Day) (Year)

7-AGE.

43 yrs. *10* mos. *29* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

Barber

9-BIRTHPLACE. (State or Country).

Germany

10-NAME OF FATHER.

Wm Martin

11-BIRTHPLACE OF FATHER. (State or Country).

Germany

12-MAIDEN NAME OF MOTHER.

Elizabeth Kraft

13-BIRTHPLACE OF MOTHER. (State or Country).

Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Emma Martin*

(Address) *1902 W. Lombard St.*

15-

NOV 15 1922

ROBERT R. KRAUTER

Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH.

Nov 11 192*2*
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Autopsy* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Autopsy* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Septicaemia

CONTRIBUTORY (Secondary)

(Duration) *10* yrs. *10* mos. *10* ds.

was cut on left arm in a fight

(Signed) *Thos. B. Stinson* M. D.

(Coroner.) *Thos. B. Stinson*

192*2*. (Address) *Curtis Bay*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.... yrs. mos. ds. In the State.... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.

London Park Cemetery

DATE OF BURIAL.

Nov 15 192*2*

20-UNDERTAKER.

Harvey H. Witzke

ADDRESS

1531 W. Lombard St.

Instructions

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Engineer*, *Civil Engineer*, *Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs*, *meninges*,

peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis*, *tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion, *Hemorrhage*, *Meningitis*, *Phlebitis*,
Cellulitis, *Gangrene*, *Miscarriage*, *Pyemia*,
Childbirth, *Gastritis*, *Necrosis*, *Septicemia*,
Convulsions, *Erysipelas*, *Peritonitis*, *Tetanus*.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides*, *Homicides*, *Abortions* (if induced), whether death is directly or indirectly due to same.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69209
Registered No. C9

1-PLACE OF DEATH

City of BALTIMORE: (No. *Bay View*)

St. *76*

Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Abraham Banks

(Residence in Baltimore: No. *Unknown*)

St.; yrs. *6 about* mos. *about* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *male* 4-COLOR OR RACE, *Black* 5-Single, Married, Widowed, or Divorced, (Write the word.) *Single*

6-DATE OF BIRTH, *Unknown* (Month) (Day) (Year)

7-AGE, *about 32* yrs. *—* mos. *—* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Laborer* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country) *Washington DC*

PARENTS. 10-NAME OF FATHER, *Unknown* 11-BIRTHPLACE OF FATHER, (State or Country), *Unknown* 12-MAIDEN NAME OF MOTHER, *Unknown* 13-BIRTHPLACE OF MOTHER, (State or Country), *Unknown*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) *Ida Scofield* (Address) *245 So. Dallas St*

15. *ROBERT R. KRAUTER,* Filed *NOV 15 1922* 1922 Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 11* (Month) (Day) 192*2* (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an *Inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *Inquiry* find that said deceased came to death topsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows: *Heart & Atherosclerosis* (Duration) yrs. *—* mos. *—* ds.

CONTRIBUTORY (Secondary) *None* (Duration) yrs. *—* mos. *—* ds. (Signed) *Nov 14 1922* (Address) *Fort on Curtis Bay* M. D.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether accidental, Suicidal, or Homicidal. *Heart & Atherosclerosis*

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Asylums, or Recent Residents). At place of death, yrs. *—* mos. *—* ds. In the State, yrs. *—* mos. *—* ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL, *Ashbury Crem.* DATE OF BURIAL, *Nov 15* 192*2*

20-UNDERTAKER, *Mrs J. G. Locks* ADDRESS *1302 Jefferson St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D69210

269210
1-PLACE OF DEATHCITY OF BALTIMORE: (No. *Bay View Hospital* ST. *4* WARD)2-FULL NAME *Mary A. Bensinger*(a) RESIDENCE NO. *419 West* ST. *4* WARDLength of residence in city or town where death occurred *47* yrs. *0* mos. *4* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *D. Bensinger*6 DATE OF BIRTH (month, day, and year) *Nov 10-18 75*7 AGE *47* Years *0* Months *4* Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Housework*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *md* (State or country)10 NAME OF FATHER *Andrew Starobitz*11 BIRTHPLACE OF FATHER (city or town) *Berlin* (State or country)12 MAIDEN NAME OF MOTHER *Mary E. Dineen*13 BIRTHPLACE OF MOTHER (city or town) *Balto* (State or country)14 Informant *Chas. T. Starobitz* (Address) *Paradiseville*15 Filed *15* 19 *22* *ROBERT N. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 14 19 22*17 I HEREBY CERTIFY, That I attended deceased from *Nov. 11 19 22* to *Nov. 14 19 22*, that I last saw her alive on *Nov. 13 19 22*, and that death occurred, on the date stated above, at *7:15 a. m.*

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? *Unknown*Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Clinical*(Signed) *H. F. Smith* M. D.(Address) *Bay View Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

*Springfield Md*20 UNDERTAKER *Wm J. Dickner & Sons*DATE OF BURIAL *Nov 16, 22*ADDRESS *N. V. Pa*

Attention should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1610 W. North Ave. Ward 15)

Registered No. C.....

2-FULL NAME

Herman C. Fette

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1610 W. North Ave. St. 58 yrs. 11 mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, Dec. 27, 1864 (Month) (Day) (Year)

7-AGE, 58 yrs. 11 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Carpenter (b) General nature of industry, business, or establishment in which employed (or employer), R. R.

9-BIRTHPLACE, (State or Country), Balto. Md.

10-NAME OF FATHER, Chas. Fette

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Christina Friedrich

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant), Otto Markula

(Address), 1610 W. North Ave.

15-

NOV 15 1922 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk,

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 12, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

suicide by hanging (Duration) yrs. mos. ds.

CONTRIBUTORY Temporary Insanity (Secondary) (Duration) yrs. mos. ds.

(Signed) J. T. Hennessy M. D. (Address) 2805 E. Canton St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

London Park Cem. Nov. 13, 1922

20-UNDERTAKER, ADDRESS

Josiah Syfer 1600 W. North Ave.

D69212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 D69212

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Argyle ST.: 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Wm E. Kent

(a) RESIDENCE. NO.

1408 Argyle

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

40 yrs.

mos.

ds. How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 Single, Married, Widowed,

or Divorced (write the word)

Married5a If married, widowed or divorced
HUSBAND of
(or) WIFE ofBlauche Feyt

6 DATE OF BIRTH (month, day, and year)

(Married) 1857

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.65

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of workTiler(b) General nature of industry,
business, or establishment in
which employed (or employee)Lecky Bros

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)Md

10 NAME OF FATHER

Unknown11 BIRTHPLACE OF FATHER (city or town)
(State or country)Md

12 MAIDEN NAME OF MOTHER

Unknown13 BIRTHPLACE OF MOTHER (city or town)
(State or country)Md

14

Informant
(Address)Blauche Feyt
1406 Argyle

15

Filed

NOV 15 1922ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 12 1922

17

HEREBY CERTIFY, that I attended deceased from

May 6, 1922, to Nov 11, 1922that I last saw him alive on Nov 11, 1922and that death occurred, on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Gastric
CatarahCONTRIBUTORY
(Secondary)Exhaustion(duration) 2 yrs. 2 mos. 2 ds.18 Where was disease contracted
if not at place of death?at home

Did an operation precede death?

no

Was there an autopsy?

no

What test confirmed diagnosis?

clinical

(Signed)

J. B. Hughes, M. D.

Nov 13 1922 address)

1413 S. 7th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Unknown11/15/22

20 UNDERTAKER

Samuel P. DeckerADDRESS 578

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No other history

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69213

1-PLACE OF DEATH

City of BALTIMORE: (No. 419 N. Calvert St., 4th Ward)

Registered No. C.

2-FULL NAME

(Residence in Baltimore: No. St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *White* 5-Single, Married, Widowed, or Divorced. (Write the word.) *Single*

6-DATE OF BIRTH (Month) (Day) (Year)

7-AGE *63* yrs., mos., ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employee).

9-BIRTHPLACE (State or Country).

PARENTS 10-NAME OF FATHER. 11-BIRTHPLACE OF FATHER (State or Country). 12-MATERN NAME OF MOTHER. 13-BIRTHPLACE OF MOTHER (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) (Address)

15- Filed. 1922. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH *Nov 8* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: *Self-due to heart* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Signed) *W. J. ...* M. D. 1922 (Address) *1639 Bay*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death, yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death?

Former or usual residence *Buffalo N. Y.*

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL. *St Vincent Cemetery 11/17 1922*

20-UNDERTAKER, ADDRESS. *Ed Fanning & Son 1435 E. Lexington*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

1069214

D62214

CERTIFICATE OF DEATH

101-001 D62214

PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE (No.

1140 Cooks

ST. WARD)

FULL NAME

Rose Weidenhoff

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No.

1140 Cooks

St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female 4-COLOR OR RACE White 5-SINGLE, MARRIED, WIDOWED OR DIVORCED Married

6-DATE OF BIRTH (Month) (Day) (Year) 1879

7-AGE 43 yrs. - mos. - ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) Housework

9-BIRTHPLACE (State or country) Germany

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Anna Youngbauer

(Address)

1140 Cooks St.

15.

Filed

191

ROBERT R. KRAUTER,

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH

November 13, 1917

17- I HEREBY CERTIFY, That I attended deceased from Nov. 11, 1917, to Nov. 13, 1917

that I saw her alive on Nov. 13, 1917

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Contributory (SECONDARY)

Influenza

(Signed),

Thos. F. Stevens

11/14, 1917

(Address) 2878 Harford Rd. M. D.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

Spec. - 1-10-21 - M&T - 1500 Bks. ✓ 1069215

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be stated EXACTLY.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69215

CERTIFICATE OF DEATH.

161-001

D69215

1-PLACE OF DEATH

CITY OF BALTIMORE: No.

3549 Chestnut Ave

ST.

WARD 13

2-FULL NAME

Daniel Joseph Younger

(a) RESIDENCE No.

3549 Chestnut Ave

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

ys.

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *W* 5 Single, Married, Widowed, or Divorced, (write the word) *Infant*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov 14 - 22

7 AGE

1 1/2 yrs

Months

Days

If LESS than 1 day, 1/2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Robert H. Younger

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Fredrick Baltimore

12 MAIDEN NAME OF MOTHER

Edna L. Trazier

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore

14

Informant (Address)

Robert H. Younger

15

Filed

19

ROBERT H. KRAUTER

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 14 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 14 19 22, to Nov 14 19 22,

that I last saw him alive on Nov 14 19 22,

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Premature birth about 6 1/2 mo died in half hour (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

W

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

none

(Signed)

Harry C. Acquisti M. D.

, 19

(Address)

3640 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

ROYAL

St Marys Hospital

Nov 15 19 22

UNDERTAKER

ADDRESS

Chenoweth Son Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - I-10-21 - MAT - 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69216

CERTIFICATE OF DEATH.

161-001

D69216

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3549 Chestnut ave* ST. *3* WARD)

2-FULL NAME

(a) RESIDENCE NO. *3549 Chestnut ave* ST. *3* WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *m*

4 COLOR OR RACE *r*

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Nov 14 - 22*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which: employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *3549 Chestnut ave*

10 NAME OF FATHER *Robert H. Younger*

11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore*

12 MAIDEN NAME OF MOTHER *Edna L. Feagler*

13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore*

14

Informant (Address) *Robert H. Younger*

15

Filed *NOV 15 1922*

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 14 19 22*

17

I HEREBY CERTIFY, That I attended deceased from *Nov 14*, 19 *22*, to *Nov 14*, 19 *22*.

that I last saw him alive on _____, 19 _____.

and that death occurred, on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Premature Birth
Born dead - age about 6 1/2 mo
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of _____

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Larry C. Alger*, M. D.

, 19 (Address) *3640 Roland ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St Marys Hospital *Nov 15 19 22*

20 UNDERTAKER

ADDRESS

Chenoweth Son Chestnut

Physicians should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 69217

DC0017

CERTIFICATE OF DEATH.

101-001

DC0017

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 339 S. 3rd St.

ST. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta C. M. Schluderberg.

(a) RESIDENCE No. 339 S. 3rd St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female

White

Married

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Wm Schluderberg of C.

6 DATE OF BIRTH (month, day, and year) Apr 28 th 1876

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

46

6

16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

10 NAME OF FATHER John Kurtz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Agnes Louisa Ray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Schluderberg of C/ (Address) 339 S. 3rd St.

15 NOV 15 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH (month, day, and year) Nov 13 1922

17

I HEREBY CERTIFY, That I attended deceased from Oct. 26, 1922, to Nov. 13, 1922.

that I last saw h alive on Nov. 13, 1922.

and that death occurred, on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Labar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

Phlebitis

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

E. J. Milton

M. D.

Nov 14 1922 (Address) 1711 E. Barks St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Oak Lawn Cemetery

Nov 17 1922

20 UNDERTAKER

John Ulrich

ADDRESS

2008 Hillman

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69218

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 319 N. Belair Rd. St. 27 Ward)

Registered No. C.....

2-FULL NAME Charles H. Chambers

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 319 N. Belair Rd. St.; yrs. 1 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male 4-COLOR OR RACE, White 5-Single, Married, Widower or Divorced, (Write the word.)

6-DATE OF BIRTH, Dec 25, 1964 (Month) (Day) (Year)

7-AGE, 67 yrs. 10 mos. 17 ds. If LESS than 1 day,hrs. ormin.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, Pressman (b) General nature of industry, business, or establishment in which employed (or employer), Printing

9-BIRTHPLACE, (State or Country), Balto Md

10-NAME OF FATHER, Robt. A. Chambers

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Sarah Carter

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THIS ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Signature) Miss Annie Chambers

(Address) 319 N. Belair Rd.

15- Robert F. Harrison

Filed NOV 15 1922

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dead Gas Asphyxiation (accidental) (Duration) 2 yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) John H. Patterson (Duration) 2 yrs. 2 mos. 2 ds.

(Signed) John H. Patterson M. D. (Coroner.) 11-14, 1922 (Address) 108 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death,yrs.mos.ds. In the State,yrs.mos.ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Holy Redeemer Cemetery Nov. 16, 1922

20-UNDERTAKER, ADDRESS

Fullerton

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1730 Goshueh*)ST. *9* WARD

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *James T. Lowe*(Residence in Baltimore: No. *1730 Goshueh* avSt.; *25* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Married

6-DATE OF BIRTH,

*September 28**1861*

(Month)

(Day)

(Year)

7-AGE,

61 yrs., *10* mos., *14* ds.

If LESS than 1 day,

...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Machine

9-BIRTHPLACE,

(State or Country),

Goshueh Pa

10-NAME OF FATHER,

Talbot Lowe

11-BIRTHPLACE OF FATHER

(State or Country),

Pa

12-MAIDEN NAME OF MOTHER

Mara E. Chayth

13-BIRTHPLACE OF MOTHER

(State or Country),

Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Wm. James Lowe*(Address) *1730 Goshueh av*

15-

Robert F. Harrison,

15-1922

Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH

*November**14*, *1922*

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

October 1, *1922*, to *Nov 14*, *1922*,that I saw him alive on *November 13*, *1922*,and that death occurred, on the date stated above, at *330* m.

The CAUSE OF DEATH* was as follows:

*Valvular disease of the**Heart**About* (Duration) yrs. *6* mos. ds.

CONTRIBUTORY (Secondary)

Exhaustion(Duration) yrs. *5* mos. ds.(Signed) *Wm. James Lowe* M. D.*1730 Goshueh av* (Address) *1730 Goshueh av*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Fallston Md

DATE OF BURIAL,

Nov. 16, 1922

20-UNDERTAKER

Wm. Cook

ADDRESS

502 E. North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1730 GORENECH AVE ST. 9

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah V. Lume

(Residence in Baltimore: No. 1730 GORENECH AVE St. 25 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.

Female

4-COLOR OR RACE,

White

5-SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED,

(Write the word.)

Without

6-DATE OF BIRTH.

1858

(Month)

(Day)

(Year)

7-AGE,

64

yrs.

mos.

da.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

Housewife

9-BIRTHPLACE,
(State or Country),

Maryland

10-NAME OF FATHER,

James Preston

11-BIRTHPLACE OF FATHER
(State or Country),

Maryland

12-MAIDEN NAME OF MOTHER

Mary Abigail

13-BIRTHPLACE OF MOTHER
(State or Country),

Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Don Miller

(Address)

1730 GORENECH AVE

15-

Filed

Robert P. Harrison,

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

March

14

1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Mar 12

1922, to

March 14

1922,

that I saw him alive on

March 14

1922,

and that death occurred, on the date stated above, at

10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Young, M. D.

(Address) 1730 GORENECH AVE

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Fallston, Md

11/16/1922

20-UNDERTAKER

ADDRESS

Wm. L. K., 502 E. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69221

D69221

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1210 Mt. Royal Ave.* ST.: *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Susan Myggandru Tyles*(a) RESIDENCE, No. *1210 Mt. Royal Ave.* ST.: WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *60* yrs. *0* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

*Maiden Lady*6 DATE OF BIRTH (month, day, and year) *March 26 1840*7 AGE Years *82* Months *7* Days *18* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Virginia* (State or country)10 NAME OF FATHER *James Tyles*11 BIRTHPLACE OF FATHER (city or town) *Virginia* (State or country)12 MAIDEN NAME OF MOTHER *Not known*13 BIRTHPLACE OF MOTHER (city or town) *Not known* (State or country)14 Informant *Mrs. J. Tyles Gray* (Address) *1210 Mt. Royal Ave.*15 *151922* *Robert H. Harris*

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 14 1922*17 I HEREBY CERTIFY, That I attended deceased from *Nov. 9 1922*, to *Nov. 14 1922*, that I last saw her alive on *Nov. 14 1922*, and that death occurred, on the date stated above, at *9.30 P. m.*

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia(duration) yrs. mos. ds. *5*CONTRIBUTORY *Infirmities of Old Age.* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted *1210 Mt. Royal Ave.* if not at place of death?Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Her symptoms, etc.*(Signed) *William V. Mark* M. D.19 (Address) *1318 Linden Ave.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenmount Cemetery *Nov. 16 1922*

20 UNDERTAKER

Wilbur W. Shriver

ADDRESS

1018 Edmondson Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D62222

CERTIFICATE OF DEATH.

D62222

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. Station Hospital, Camp Holabird, Md. ST. 188-004 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin G. Shrader,

(a) RESIDENCE. NO. Post Field, Ft. Sill, Okla. ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Not known yrs. -- mos. -- ds. How long in U. S., if of foreign birth? Not known yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced (write the word) Not known

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE 27 Years 7 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 1st Lieut. A.S., USA.

(b) General nature of industry, business, or establishment in which employed (or employer) Soldier

(c) Name of employer

9 BIRTHPLACE (city or town) Iowa. (State or country)

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Camp Holabird, Md. (Address)15 Filed Robert P. Hollander Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 14, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov. 14, 1922, to Nov. 14, 1922,

that I last saw him alive on

and that death occurred, on the date stated above, at 10:45 a. m.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds. CONTRIBUTORY Accidental fall of biplane (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? (Signed) C. H. Witherell, Major, M. D.

19 (Address) Station Hospital, Camp Holabird, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

IOWA city IOWA 11/15 1922

20 UNDERTAKER ADDRESS

Jack Lewis 1439 E. Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

✓
TIMORE
52

D69223

1. PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2125 Madison ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 2125 Madison Ave ST., WARD 11
(Usual place of abode) (If applicable)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 Single, Married, Widowed, or Divorced, (write the word) <i>Widowed</i>
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5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 00 1841

7 AGE	Years 81	Months 7	Days 15	If LESS than 1 day.....hrs or.....min.
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8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) **Name of employer**

9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER *Geo. Frohman*

II BIRTHPLACE OF FATHER (city or town) San Francisco
(State or country)

12 MAIDEN NAME OF MOTHER *Not known*

13 BIRTHPLACE OF MOTHER (city or town) Gen
(State or country)

14 Informant Mr Minnie Reese
(Address) 3125 Madison Ave

15 Robert F. HARRISON,
5-1492, 19

[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 1962

17

I HEREBY CERTIFY, That I attended deceased from
Oct 19*18* to *Nov 14th* 19*22*
Dec that I last saw *her* alive on *Nov. 14th* 19*22*

and that death occurred, on the date stated above, at 810 W m

The CAUSE OF DEATH* was as follows:

Marling & Marling
New York after Aug
4 Oct 1918

CONTRIBUTORY *Chronic Asthenic Reaction*
(Secondary) (duration) *3* yrs mos. ds

18 Where was disease contracted
if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? *Viral*

(Signed) Ed Smith M.D.

20432 (Address) 1605 N. North Av

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL
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W. A. Brown, Esq. 10/16/16

20 UNDERTAKER	ADDRESS
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Don Cook

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69224

CERTIFICATE OF DEATH.

D69224

1-PLACE OF DEATH

Woman's Hospital
Baltimore City

REGISTERED NO.

(If death occurred in
a hospital or institu-
tion, give its NAME
instead of street and
number.)

CITY OF BALTIMORE: No.

ST.

WARD)

2-FULL NAME

Jean Patterson Reid

(a) RESIDENCE NO.

4204 Springdale Ave.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

39 yrs. 10 mos. 4 ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed,
or Divorced, (write the word)

Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan 10, 1883

7 AGE

Years

Months

Days

If LESS than
1 day, hrs
or min.

39

10

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Secretary -

(b) General nature of industry,
business, or establishment in
which employed (or employer)

Library

(c) Name of employer

Medical & Chiropractic Library
Baltimore Md.9 BIRTHPLACE (city or town)
(State or country)

10 NAME OF FATHER

Charles Doro Reid

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Baltimore
Maryland

12 MAIDEN NAME OF MOTHER

Sarah D. Townsend

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)New Brighton
Pennsylvania

14

Informant
(Address)John M. Reid
4204 Springdale Ave

15

Filed

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 14 1922

17

I HEREBY CERTIFY, That I attended deceased from
Nov 12, 1922, to Nov 12, 1922.

that I last saw her alive on

Nov 14, 1922

and that death occurred, on the date stated above, at 11:55 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

CONTRIBUTORY
(Secondary)

Intestine

(duration)

yrs.

mos

ds.

(duration)

yrs.

mos

ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Yes Date of Nov 14, 1922

Was there an autopsy?

No

What test confirmed diagnosis?

Operation

(Signed)

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

DATE OF BURIAL

Woodlawn Cemetery

Nov 17 1922

20 UNDERTAKER

ADDRESS

Woodlawn Cemetery

3036 North
Ave

D69225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

180-001 D69225
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2808 Parkview Ter St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maria Z. Hudson(Residence in Baltimore: No. 2808 Parkview Ter St. 2 yrs. — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. <u>Female</u>	4-COLOR OR RACE. <u>white</u>	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. <u>widow</u> (Write the word.)
6-DATE OF BIRTH. <u>July 30, 1932</u> (Month) (Day) (Year)		
7-AGE. <u>70</u> yrs. <u>3</u> mos. <u>10</u> ds.		IF LESS than 1 day, ...hrs. or...min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer).		
9-BIRTHPLACE. (State or Country), <u>New York State</u>		
PARENTS.	10-NAME OF FATHER, <u>Wm. Scott Jameson</u>	
	11-BIRTHPLACE OF FATHER (State or Country), <u>Vermont</u>	
	12-MAIDEN NAME OF MOTHER <u>Almira Rowley</u>	
	13-BIRTHPLACE OF MOTHER (State or Country), <u>Conn.</u>	

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myra Ale(Address) 2808 Parkview Ter

15-

Filed Robert P. Harrison 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15th, 1972
(Month) (Day) (Year)17- I HEREBY CERTIFY, That I attended deceased from Nov. 8th, 1972, to Nov. 15th, 1972, that I saw her alive on Nov. 14th, 1972, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Branches pneumonia
(Duration) — yrs. — mos. 7 ds.CONTRIBUTORY arterio-sclerosis
(Secondary)(Signed) Eugene Douglas M. D.
Nov. 15th, 1972 (Address) 830 W. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

51922

Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Physicians should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 1-10-21 M&T 1500 Ills.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69226

CERTIFICATE OF DEATH.

D69226

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *2027 Fleet*)

ST. *V* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Charles Apson*

(a) RESIDENCE No. *2027 Fleet*
(Usual place of abode)

ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *March 23 1922*

7 AGE Years Months Days If LESS than 1 day, hrs or min. *7 23*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore*
(State or country)

10 NAME OF FATHER *Walter Apson*

11 BIRTHPLACE OF FATHER (city or town) *Balto*
(State or country)

12 MAIDEN NAME OF MOTHER *Dora Holodzieyska*

13 BIRTHPLACE OF MOTHER (city or town) *Poland*
(State or country)

14 Informant *Walter Apson*
(Address) *2027 Fleet St*

15 *Robert P. Harrison*
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 14 1922*

17 I HEREBY CERTIFY, That I attended deceased from *Nov 10*, 1922, to *Nov 15*, 1922, that I last saw him alive on *Nov 15*, 1922, and that death occurred, on the date stated above, at *530 P. m.*

The CAUSE OF DEATH* was as follows:

acute gastric enteritis

(duration) yrs. mos. *6* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *J. M. Santos*, M. D.

(Address) *#14 S. Bury*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

John A. Weber *1803 Bank St*

PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1590 Bks.

D69227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. *Smith Falls Gen Hosp 73* ST., *73* WARD)

2-FULL NAME *Margaret Bauman*

(a) RESIDENCE NO. *131 W. Clement* ST., *73* WARD

(Usual place of abode)

Length of residence in city or town where death occurred *28* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Herbert C Bauman*

6 DATE OF BIRTH (month, day, and year) *Nov 6 1895*

7 AGE Years *27* Months *-* Days *7* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town, State or country) *St Mary Co Md*

10 NAME OF FATHER *Thomas J. Airey*

11 BIRTHPLACE OF FATHER (city or town, State or country) *Dorchester Co Maryland*

12 MAIDEN NAME OF MOTHER *Mary F. Bell*

13 BIRTHPLACE OF MOTHER (city or town, State or country) *St Mary Co Maryland*

14 Informant *Mrs Mary F Airey* (Address) *1830 N. Charles st*

15 *Met* *Nov 16 1922* *ROBERT R. KRAUTER,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 13 1922*

17 I HEREBY CERTIFY, That I attended deceased from *October 30*, 19*22*, to *Nov 13*, 19*22*.

that I last saw him alive on *November 13*, 19*22*,

and that death occurred, on the date stated above, at *9:30* m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. *4* ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *Yes* Date of *10/31/22*

Was there an autopsy? *No*

What test confirmed diagnosis?

(Signed) *John A. Bauman* M. D.

19 (Address) *Smith Falls Gen Hosp*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Western Cemetery

Nov 16 1922

20 UNDERTAKER

ADDRESS

John F. Denny

715 Light St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

Length of residence in city or town where death occurred

50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced

HUSBAND of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

NOV 16 1922

ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 10, 1922, to Nov 14, 1922,

that I last saw him alive on Nov 14, 1922,

and that death occurred, on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodor H. Morrison, M. D.

, 19 (Address) 1013 7 Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69229

CERTIFICATE OF DEATH.

D69229

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. NO.

(Usual place of abode)

ST.

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

NOV 16 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 11, 1922

17

I HEREBY CERTIFY, That I attended deceased from November 13, 1922, to November 15, 1922, that I last saw him alive on November 15, 1922, and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration)

yrs.

mos.

7 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

, 19 (Address)

M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19-H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69230

CERTIFICATE OF DEATH.

101-001

D69230

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 E. Chan ST. 71 WARD)

2-FULL NAME Michael J Buckley

(a) RESIDENCE. NO. 807 E. Chan ST. WARD.

(Usual place of abode) Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Buckley

6 DATE OF BIRTH (month, day, and year) June 3 1860 7 AGE 62 Years 5 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Martin Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Monaghan (Address) 807 E. Chan St.

15 NOV 16 1922 M. J. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15-1922

17 I HEREBY CERTIFY, That I attended deceased from 11-13 1922, to 11-15 1922,

that I last saw him alive on 11-14 1922,

and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) yrs. mos. 3 ds. CONTRIBUTORY (Secondary) edema of lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Edwards, M. D.

(Address) 914 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Cemetery Nov 17 1922

20 UNDERTAKER ADDRESS

H. C. Woodfield 914 Green Mt.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69231

CERTIFICATE OF DEATH.

REGISTERED NO.

D69231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor, ST. 10* WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary McGovern*(a) RESIDENCE. NO. *Preston Valley Hs. ST.* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *40* yrs. mos. ds. How long in U. S., if of foreign birth? *40* yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of*Patrick McGovern*6 DATE OF BIRTH (month, day, and year) *1855*7 AGE Years *67* Months *-* Days *-* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Ireland*
(State or country)10 NAME OF FATHER *Thomas Conroy*11 BIRTHPLACE OF FATHER (city or town)
(State or country) *in Ireland*12 MAIDEN NAME OF MOTHER *Margaret Doyle*13 BIRTHPLACE OF MOTHER (city or town)
(State or country) *in Ireland*14 Informant *Lester Forman*
(Address) *Little Sisters of the Poor*15 Filed *NOV 16 1922*
ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 15 1922*17 I HEREBY CERTIFY That I attended deceased from *Nov 8* to *Nov 12*, 19*22*.that I last saw him alive on *Nov 12*, 19*22*.and that death occurred, on the date stated above, at *6:50 a.m.*

The CAUSE OF DEATH* was as follows:

*Carcinoma (Gastric)**Unknown* (duration) yrs. mos. ds.CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. A. Warner*, M. D.15, 1922 (Address) *1133 Valley Hs.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral Nov 17 1922

20 UNDERTAKER ADDRESS

H. C. Wiedefeld 914 Green Mt.

Information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69232

CERTIFICATE OF DEATH.

D69232

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1809 W Balto.*ST. *19*

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Louise K. Meyer

(a) RESIDENCE. NO.

1809 W Baltimore

ST.

WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

66 yrs. *9* mos. *1* w.

How long in U. S., if of foreign birth?

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Charles Meyer.

6 DATE OF BIRTH (month, day, and year)

March 2nd 1836

7 AGE

86

Years

Months

Days

If LESS than 1 day, hrs. or min.

*8.**12*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany.

10 NAME OF FATHER

Henry Ringling

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Germany.

12 MAIDEN NAME OF MOTHER

Mary Island.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Germany

14

Informant (Address)

Charles Meyer

15

NOV 13 1922

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 14* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from

Jan, 19*21*, to *Nov. 14*, 19*22*;that I last saw him alive on *Nov. 14*, 19*22*;and that death occurred, on the date stated above, at *2:2* m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis(duration) *2* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Maemia(duration) *1* yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *clinical*(Signed) *John H. Hoff* M. D., 19 (Address) *1243 W Balto St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Louisa Park Cemetery *Nov 16* 19*22*

20 UNDERTAKER

ADDRESS

H. B. Hoff *2116 Fred St*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69233

CERTIFICATE OF DEATH.

D69233

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 729 W. North Avenue ST. 14 WARD)

2-FULL NAME Thomas J. Meehan

(a) RESIDENCE No. 729 W. North Avenue

ST. 14 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

Mos.

Ds.

How long in U. S., if of foreign birth?

Yrs.

Mos.

Ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Jan. 7 1852

7 AGE

Years

Months

Days

If LESS than 1 day, ... hrs or ... min.

70

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

Canned fruits & vegetables

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Maryland

10 NAME OF FATHER

Patrick Meehan

11 BIRTHPLACE OF FATHER (city or town) (State or country)

County Mayo Ireland

12 MAIDEN NAME OF MOTHER

Mary A. Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Glasgow Scotland

14

Informant (Address)

C. Shriver Duff Highland Ave. Mt. Washington

15

NOV 16 1922

ROBERT R. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1 1920 to Nov 14 1922

that I last saw him alive on Nov 14 1922

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Diabetic Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Edwin E. Meyer M. D.

11/15 1922 Address 2438 Euteria Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

11/17 1922

20 UNDERTAKER

ADDRESS

Henry W. Nease & Son 605 W. Calvert

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69234

D69234

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Mercy Hospital* ST. *1* WARD)

2-FULL NAME

(a) RESIDENCE NO. 816 E. 33rd ST. 12 WARD

(Usual place of abode)			(If non-resident give city or town and State)				
Length of residence in city or town where death occurred	hrs.	mos.	ds.	How long in U. S., If of foreign birth?	hrs.	mos.	ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
-------	-----------------	--

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of *March 18th 1881*

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	41.	7.	27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeping

(b) General nature of industry, business, or establishment in which employed (or employer) *Shoe Business*

(c) Name of employer United States Army

9 BIRTHPLACE (city or town), Baltimore
(State or country) md

10 NAME OF FATHER *Michael J. Maher*

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) *Co. Tipperary, Ireland*

12 MAIDEN NAME OF MOTHER *Julia A. Maher*

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) *Co. Tipperary Ireland*

14 Informant Mrs John V. Lewis

(Address) 326 E. 22nd St

15 NOV 16 1932 ROBERT A. KRAUTER.
Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from
Apr 22, 1922... to Nov. 15, 1922.

that I last saw him alive on Nov. 15 1942.

and that death occurred, on the date stated above, at 5-20 PM.

The CAUSE OF DEATH* was as follows:

Myocodites

(duration) 2 yrs. 1 mos 0 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs | mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? No Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) _____

, 19 (Address) 0 Mrs. [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-	DATE OF BURIAL

11/18/31

20 **FOUNDER TAKER** ADDRESS

[Handwritten signature]

W H Mass + Gen FAS N/Quint

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69235

1-PLACE OF DEATH

City of BALTIMORE: (No. 1517 Myrtle Ave. St. 14 Ward)

Registered No. C. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1517 Myrtle Ave. St. 14 yrs. 18 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female colored
4-COLOR OR RACE, colored
5-Single, Married, Widowed, or Divorced (Write the word.)

6-DATE OF BIRTH, March 891
(Month) (Day) (Year)

7-AGE, 31 yrs. 18 mos. ds. If LESS than 1 day, hrs. or min. 2

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, cook
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Va

10-NAME OF FATHER, John Ross

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, LK

13-BIRTHPLACE OF MOTHER, (State or Country), LK

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas. E. Stokes

(Address) 1517 Myrtle Ave

15- NOV 13 1922 ROBERT R. KRAUTER, Registrar.

Filed 1922 Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 13, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest, autopsy or inquiry, thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardic heart disease

(Duration) 1 yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) 1 yrs. 18 mos. ds.

(Signed) J. T. Henderson, M. D. (Coroner)

Nov 14, 1922 (Address) 280 E. Lexington St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death, yrs. 18 mos. ds. In the State, yrs. 18 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Mc Auburn Nov 16, 1922

20-UNDERTAKER, ADDRESS

Edward Pungold 1463 Carey St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Hks.

D69236

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69236

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Edmondson Ave. ST. 17 WARD)

2. FULL NAME Louis S. Dieterich

(a) RESIDENCE NO. 824 Edmondson Ave. ST. 17 WARD

(Usual place of abode)
Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth H. Dieterich

6 DATE OF BIRTH (month, day, and year) April 8, 1842

7 AGE Years 80 Months 7 Days 7 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Dean L. Dieterich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elphie Gerding

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant C. Theodore Dieterich (Address) 824 Edmondson Ave.

15 Filed NOV 16 1922 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15, 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922 to Nov 15, 1922, that I last saw him alive on Nov 14, 1922

and that death occurred, on the date stated above, at 3 A. M. The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Myocarditis

(duration) 10 yrs. mos. ds. CONTRIBUTORY Silicosis Osseum Pharynx (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Joseph E. Glickman, M. D.

(Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park DATE OF BURIAL Nov 17, 1922

20 UNDERTAKER Mr. Mrs. W. Teufelsbach ADDRESS 801 N. Fayette

D69237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69237

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1138 Scott* ST. *2* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Frederick Nazaremus*(a) RESIDENCE NO. *1138 Scott* ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *48* yrs. *6* mos. *12* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Margaret Nazaremus*6 DATE OF BIRTH (month, day, and year) *May 2nd 1874*7 AGE Years *48* Months *6* Days *12* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Iron finisher*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Baltimore Md.*10 NAME OF FATHER *Christian Nazaremus*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Baltimore Md.*12 MAIDEN NAME OF MOTHER *Mary Schlag*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Baltimore Md.*14 Informant *Margaret Nazaremus* (Address) *1138 Scott St.*15 Filed *NOV 16 1922* 19 *ROBERT R. KRAUTER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 14th 1922*17 I HEREBY CERTIFY, That I attended deceased from *August*, 19*22*, to *Nov 14*, 19*22*.that I last saw him alive on *Nov 14*, 19*22*.and that death occurred, on the date stated above, at *2:45 P.M.*

The CAUSE OF DEATH* was as follows:

Myocarditis(duration) yrs. mos. ds. *10*CONTRIBUTORY (Secondary) *Rheumatism*(duration) yrs. mos. ds. *3*

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *W. H. H. Smith*, M. D.19 (Address) *1227 Washington St.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOVAL

20 UNDERTAKER

ADDRESS

Western Cemetery *Nov 17th 1922*
Mr. & Mrs. John W. Seufel & Son *811 N. Fayette St.*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69239

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3510 O'Donnell St ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Mary E. Kipp(a) RESIDENCE NO. 3510 O'Donnell St ST., 76 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of John F. Kipp (or) WIFE of6 DATE OF BIRTH (month, day, and year) Feb. 11, 18747 AGE Years 48 Months 9 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)10 NAME OF FATHER Alexander Bosman11 BIRTHPLACE OF FATHER (city or town) Cristfield Md. (State or country)12 MAIDEN NAME OF MOTHER Barbara Hartline13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md. (State or country)14 Informant John F. Kipp (Address) 3510 O'Donnell St15 NOV 15 1922 ROBERT R. KRAUTER, RegistrarBurial Permit 11/15/22

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 13 192217 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1922 to Nov 13, 1922 that I last saw him alive on Nov 12, 1922and that death occurred, on the date stated above, at 8:45 p.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds.18 Where was disease contracted if not at place of death? NoDid an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical(Signed) W. B. Frieling M.D. M. D.(Address) 612 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL London Park Cemetery DATE OF BURIAL Nov. 17 192220 UNDERTAKER Girkler & Girkler ADDRESS 1739 E. Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69240

CERTIFICATE OF DEATH.

44

D69240

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2104 Smallwood ST., 15 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel G. Moore

(a) RESIDENCE No. 2104 Smallwood ST., WARD

(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX m. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of Ida G. Moore (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1846

7 AGE Years 76 Months 11 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED (a) Trade, profession or particular kind of work Collector Retired 072 (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) Ind (State or country)

10 NAME OF FATHER Wm Moore

11 BIRTHPLACE OF FATHER (city or town) Ind (State or country)

12 MAIDEN NAME OF MOTHER Sarah Tarbutton 11-16 1922 (Address) 1120 St Paul St.

13 BIRTHPLACE OF MOTHER (city or town) Ind (State or country)

14 Informant Ida G. Moore (Address) 2104 Smallwood

15 Filed NOV 16 1922 REGISTRAR ROBERT H. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 16- 1922, to Nov 15- 1922, that I last saw him alive on Nov 15- 1922, and that death occurred, on the date stated above, at 3:15 P.m. The CAUSE OF DEATH* was as follows:

Senile Arterio-Sclerosis (duration) 10 yrs. mos. ds. CONTRIBUTORY Carcinoma of Stomach (Secondary) (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinically (Signed) C. K. Shilling M. D.

11-16 1922 (Address) 1120 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE MOVAL Gaudon Park DATE OF BURIAL Nov 17 1922

20 UNDERTAKER Giskler Giskler ADDRESS 739 Eager

ISAAC STARK

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69241

CERTIFICATE OF DEATH.

D69241

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST.

WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No.

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

to

that I saw him alive on

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

(Duration)

CONTRIBUTORY (Secondary)

(Duration)

(Signed)

, 1912 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 16 1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Sierack) ✓
HEALTH DEPARTMENT—CITY OF BALTIMORE

D69242

CERTIFICATE OF DEATH.

D69242

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 S. Ann ST., 2 WARD)

2-FULL NAME

Mrs. Annie Sierack

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

521 S. Ann

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F 4 COLOR OR RACE W 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Sierack

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 42

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER John Dzaduszek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Jadwiga Dzaduszek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant M. F. Sadowski, for Frank Sierack (Address) 521 S. Ann St.

15 Registrar Filed NOV 16 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct, 19 22, to Nov 14, 19 22.

that I last saw him alive on Nov 12, 19 22.

and that death occurred, on the date stated above, at 10:35 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical Exam.

(Signed) A. T. Rice M. D.

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL St. Stanislaus Cem. 24 S. Bury

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

DATE OF BURIAL

20 UNDERTAKER M. F. Sadowski ADDRESS 705 S. Ann St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69243

CERTIFICATE OF DEATH.

D69243

1-PLACE OF DEATH

CITY OF BALTIMORE: (Name of Hospital, Institution, or Place) *South Balto. General Hospital* WARD *70*

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

*Male White**Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 27-1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

5 19

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto. City Md.

10 NAME OF FATHER

Frederick L. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto. City Md.

12 MAIDEN NAME OF MOTHER

Lella Evans

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md.

14

Informant

Frederick L. Miller

(Address)

334 Gwynn Ave.

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 15 1922*

17

I HEREBY CERTIFY, That I attended deceased from *November 7*, 19*22*, to *November 15*, 19*22*, that I last saw him alive on *November 15*, 19*22*, and that death occurred, on the date stated above, at *7:59* m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of *Nov 8/22*

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

John A. Connor, M. D.

19 (Address)

South Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

*Park Wood Cem.**Nov. 17 1922*

20 UNDERTAKER

ADDRESS

Mrs. A. E. Fuller 4604 Harford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 161-002

D69244

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2528 Faint Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Alma M. Auffarth

(a) RESIDENCE NO.

2528 Faint Ave

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Nov. 16, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

George Auffarth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Alma Wechsung

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

George Auffarth 2528 Faint Ave

15

Filed

Robert F. Harrison, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 16, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1922, to Nov. 16, 1922,

that I last saw her alive on Nov. 16, 1922,

and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Compression of Umbilical Cord

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Thomas B. Telford, M. D.

16, 1922 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-INTERMENT

DATE OF BURIAL

London Park Cem. Nov. 18, 1922

20 UNDERTAKER

ADDRESS

H. Sander Sons 1710 East R

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCURRENCE is very important. See instructions on back of certificates.

161-022

Serial Permit Clerk

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69245

D69245

CERTIFICATE OF DEATH.

109-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 Plile)

ST. 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 812 Plile St.

(Usual place of abode)

ST. WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) States

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) States

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) States

14

Informant (Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 14 1922, to Nov 14 1922,

that I last saw him alive on 13 day Nov 1922,

and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds. Dausette

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Henry J. Ford M. D.

11 15 1922 Address 1800 4th St. S. E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Nov 17 1922

20 UNDERTAKER ADDRESS

M. E. Duff 321 St. N. E.

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

OV 16 1922

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1500 Dka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69246

D69246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

ST., WARD)

2-FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant (Address)

15

Filed

Robert F. Harrison,

19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 11-15 19 22

17

I HEREBY CERTIFY, That I attended deceased from

Nov 13, 1922, to Nov 15, 1922,

that I last saw him alive on Nov 15, 1922,

and that death occurred, on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Ruptured urether with
Wormian infiltration to
Anterior abdominal wall +
perineum (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 11-13-22

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. H. Richardson, M. D.

, 19 (Address) Bay View Ho. sp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

New Catholic bur 2nd 17 19 22

20 UNDERTAKER

ADDRESS

J. A. Moran 6 Bect

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Gonococcus Infection

D69247

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69247

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *4000 Howard Avenue* ST. *26* WARD)2-FULL NAME *Mary C. McLean*(a) RESIDENCE. No. *132 S. Aud* ST. _____ WARD. _____

(Usual place of abode)

Length of residence in city or town where death occurred *4* yrs. *6* mos. *0* ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *X*6 DATE OF BIRTH (month, day, and year) *Feb. 1890*7 AGE Years *32* Months _____ Days _____ If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Balto-* (State or country) *md -*10 NAME OF FATHER *Geo L. McLean*11 BIRTHPLACE OF FATHER (city or town) *Westmoreland* (State or country) *England*12 MAIDEN NAME OF MOTHER *Annie Doyle*13 BIRTHPLACE OF MOTHER (city or town) *Galway* (State or country) *Ireland*14 Informant *Records of Mt Hope Hospital* (Address) *Mt Hope Hospital*15 Filed *1922* Registrar *Robert T. Harrison*

Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Mar 14 1922*17 I HEREBY CERTIFY, That I attended deceased from *Aug 9th 1915* to *Mar 14 1922*that I last saw him alive on *Mar 14 1922*and that death occurred, on the date stated above, at *10 P. m.*

The CAUSE OF DEATH* was as follows:

*Epilepsy**Abc* (duration) *17* yrs. *0* mos. *0* ds.CONTRIBUTORY *Explanation from* (Secondary) *Spasms* (duration) yrs. mos. ds.18 Where was disease contracted *Baltimore* if not at place of death?Did an operation precede death? *No* Date of _____Was there an autopsy? *No*What test confirmed diagnosis? *Frank Flannery*(Signed) *Frank Flannery* M. D., 19 (Address) *Mt Hope Retreat*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

New Cathedral Cem *Mar 18 1922*20 UNDERTAKER ADDRESS *3000**J. J. Moran* *E B alt*

Physicians should state EXACTLY. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69248

CERTIFICATE OF DEATH.

101-001 D69248

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 Kennedy St. 9 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 1914 Kennedy St. 16 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH,

(Month) (Day) (Year) 1861

7-AGE,

61 yrs., mos., ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. House Wife (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Pa

10-NAME OF FATHER, John Foster

11-BIRTHPLACE OF FATHER (State or Country), Pa

12-MAIDEN NAME OF MOTHER, Elizabeth Pence

13-BIRTHPLACE OF MOTHER (State or Country), Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. C. Harrison

(Address) 1914 Kennedy St.

15-

Filed

Robert P. Harrison,

191

Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month) (Day) (Year) Mar 14, 1912

17- I HEREBY CERTIFY, That I attended deceased from

Mar 14, 1912, to Mar 19, 1912,

that I saw him alive on Mar 14, 1912,

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Pneumonia)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas. Harrison M. D.

1014 (Address) 1014

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Lebanon Pa. Nov 15, 1912

20-UNDERTAKER, ADDRESS

Martin Hughes 1210 North

Cur

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. - 1-10-21 - M&T - 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69249

CERTIFICATE OF DEATH.

D69249

1-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 Harford Rd ST. 27 WARD)

2-FULL NAME

Francis S. Frank

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

217 Harford Rd ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 3 mos.

ds. How long in U. S., if of foreign birth? 1 yrs. 1 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Aug 14, 1916

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

6 years

3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

MD.

10 NAME OF FATHER

Late John Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country)

MD.

12 MAIDEN NAME OF MOTHER

R. Kleiderlein

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

MD.

14

Informant (Address)

Katherine Kleiderlein
217 Harford Ave

15

Filed

Robert F. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 14 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 12, 1922, to Nov 14, 1922.

that I last saw him alive on Nov 13, 1922.

and that death occurred, on the date stated above, at 14 m.

The CAUSE OF DEATH* was as follows:

Typhoid

(duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary)

Mitral Regurgitation

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted

if not at place of death?

At place of death

Did an operation precede death?

No Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Mitral

(Signed)

Henry E. Long, M. D.

, 19

(Address)

217 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Cemetery

Nov 17 1922

20 UNDERTAKER

ADDRESS

George F. Ruth 175 Harford Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69250

CERTIFICATE OF DEATH.

D69250

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Colvin ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincenzina Tallarico(a) RESIDENCE NO. 414 Colvin

(Usual place of abode)

ST., 5 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 0 mos.How long in U. S., if of foreign birth? 1 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female4 COLOR OR RACE white5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 - 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min. 6 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balti City Md10 NAME OF FATHER Salvatore Tallarico11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy12 MAIDEN NAME OF MOTHER Vincenza Annunzio13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14

Informant (Address) Salvatore Tallarico
414 Colvin St

15

Filed Robert P. Harrison,

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 19 22, to Nov 15, 19 22, that I last saw her alive on Nov 15, 19 22.and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Primary Broncho Pneumonia(duration) 2 1/2 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 2 1/2 yrs. 0 mos. 0 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of Nov 15 19 22

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi J. Di Stefano M. D.Address 407 N. Euter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer 11/17/22

20 UNDERTAKER

ADDRESS

Glo. J. Ruth 1735 Hayford Ave.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

16 1922

Burial Permit Clerk.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1900 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69251

CERTIFICATE OF DEATH.

129

D69251

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 Municipal Hospital. ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Charles Booth

(a) RESIDENCE NO.

425 Mott St.

ST.

WARD

(Usual place of abode)

(If non-resident of the city or town and State)

Length of residence in city or town where death occurred

mos.

ds.

How long in U. S., if of foreign birth

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widowed

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Widowed of Elizabeth Booth

6 DATE OF BIRTH (month, day, and year)

Aug 31 1848

7 AGE

Years

Months

Days

If LESS than 1 day, hrs or min.

? 74 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md.

10 NAME OF FATHER

James Booth

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Baltimore Md.

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md.

14

Informant (Address)

Municipal Hospital Records
Cella House 1137 Kenwood

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 16 1922

17

I HEREBY CERTIFY, That I attended deceased from November 14 1922 to November 16 1922.

that I last saw him alive on November 15 1922.

and that death occurred, on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 6 yrs. 6 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) 6 yrs. 6 mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? N.P.V.

(Signed) Chas. M. Muehl M. D.

11/16/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR RE-

DATE OF BURIAL

MOVAL
Baltimore East North

20 UNDERTAKER

ADDRESS

Monroe Oliver
William Beck 5125 North

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D 69252

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69252

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* Ward)

2-FULL NAME *George Alexander Swan*

(Residence in Baltimore: No. *Biloxi* St.; yrs. *2 weeks* mos. *2 weeks* ds.)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male*

4-COLOR OR RACE, *White*

Married
Single, Married, Widowed, or Divorced.
(Write the word.)

6-DATE OF BIRTH, *April 9 1878*

(Month) (Day) (Year)

7-AGE, *44* yrs. *7* mos. *7* ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer) *086*

9-BIRTHPLACE, (State or Country), *Wyoming*

10-NAME OF FATHER, *Wm J. Swan*

11-BIRTHPLACE OF FATHER, (State or Country), *Penn*

12-MAIDEN NAME OF MOTHER, *May R. Egan*

13-BIRTHPLACE OF MOTHER, (State or Country), *Penn*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Johns Hopkins*

(Address) *Hosp*

15-

File

NOV 17 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 16 1922*

(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry* (Inquest, au-

topsy or inquiry.) and that said deceased came to *death*

on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - Hung himself by back of the chair from head board of bed at Hospital

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. H. Carter* M. D.

(Coroner)

11-16 1922 (Address) *308 E. North*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence,

19-PLACE OF BURIAL OR REMOVAL, *Biloxi Mississippi*

DATE OF BURIAL

20-UNDERTAKER, *Lilly & Ziehl*

ADDRESS

103 S. Wolfe St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 10-21-MAT-1500 Ika.

569253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69253

CERTIFICATE OF DEATH

101-001

D69253

1. PLACE OF DEATH

Robt Garrett Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

27 N. Carey

ST.

22 WARD)

2. FULL NAME

Edward Swackebush

(a) RESIDENCE NO.

210 E. Church

ST.

22 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

Yrs.

mos.

ds.

How long in U. S., if of foreign birth?

Yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white

5 Single, Married, Widowed, or Divorced, (write the word)

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Sept 11 1918

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

4

2

5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Edward Swackebush

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Canada

12 MAIDEN NAME OF MOTHER

Lillie Culbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Lillie Swackebush 110 E Church St

15

Filed

NOV 17 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 16 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Nov 16, 1922.

that I last saw him alive on Nov 16, 1922.

and that death occurred, on the date stated above, at 7⁰⁰ P. M.

The CAUSE OF DEATH* was as follows:

Malnutrition & Emaciation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Unresolved Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

Physical Exam

(Signed)

J. W. Clift

M. D.

11/16/22 (Address) 27 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Harriett G. Par. 11/14/22
J. W. Clift 502 E. 4. Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69254

CERTIFICATE OF DEATH.

188-003

Registered No. C

1-PLACE OF DEATH

City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *3* Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Charles L. Brown*

(Residence in Baltimore: No. *108 S. Brehel* St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Male* 4-COLOR OR RACE *Black* 5-Single, Widowed, or Divorced. (Write the word.) *Single*

6-DATE OF BIRTH. *Feb 7* (Month) (Day) (Year) *1894*

7-AGE, *3* yrs. *9* mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *Chieft* (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country). *Balta Md.*

10-NAME OF FATHER. *Charles Brown*

11-BIRTHPLACE OF FATHER. (State or Country). *Md.*

12-MAIDEN NAME OF MOTHER. *Ruth Evans*

13-BIRTHPLACE OF MOTHER. (State or Country). *Md.*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Ruth Evans Brown*

(Address) *108 S. Brehel*

15-

NOV 17 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 15* (Month) (Day) (Year) *1922*

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *death* on the day stated above.

The CAUSE OF DEATH* was as follows: *Probable Cerebral Hemorrhage* *Met by Automobile* *Corner of Brehel St.* (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds. (Signed) *J. E. ...* M. D. (Coroner) *11-16* 1922 (Address) *108 S. Brehel*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Funeral Home *Nov 19th* 1922

20-UNDERTAKER. ADDRESS

Mrs. Elias B. Jones *1725 Ashland Ave.*

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

D69255

HEALTH DEPARTMENT-CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

D69255

PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

REGISTERED NO. C

ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St. 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH Mch 16, 1845 (Month) (Day) (Year)

7 AGE 77 yrs. 7 mos. 29 ds. or min. If LESS than 1 day, hrs.

8 OCCUPATION Retired (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pa

10 NAME OF FATHER Wm B Reamer

11 BIRTHPLACE OF FATHER Pa

12 MAIDEN NAME OF MOTHER Abigail E. Mann

13 BIRTHPLACE OF MOTHER Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sadie V. Reamer

(Address) 2614 N Charles St

NOV 17 1922

Filed 1922

ROBERT R. KRAUTER,

Burial Permit REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Nov 15th, 1922 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Nov 13th, 1922 to Nov 15th, 1922 that I saw him alive on Nov 15th, 1922 and that death occurred, on the date stated above, 10:30 AM. The CAUSE OF DEATH* was as follows:

Brooke-Pneumonia

Contributory (SECONDARY) Acute Cardiac Distention (Duration) yrs. mos. ds.

(Signed) Andrew J. Orum M. D. (Address) 2847 W. Calver St, 191

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence

19 PLACE OF BURIAL OR REMOVAL London Park DATE OF BURIAL Nov 18, 1922

20 UNDERTAKER John O. Mitchell ADDRESS 1701 W. Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69256

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *620 Raborg*)

St. *4*

Ward

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Josephine Thornton*

(Residence in Baltimore: No. *620 Raborg*)

St.; yrs. *35* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *Colored* 5-Single, Married, Widowed, or Divorced. *Single*
(Write the word.)

6-DATE OF BIRTH. 1
(Month) (Day) (Year)

7-AGE. *5-8* yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work *Laundress*
(b) General nature of industry, business, or establishment in which employed (or employer) *OH*

9-BIRTHPLACE, (State or Country). *Md.*

PARENTS.
10-NAME OF FATHER. *Don't Know*
11-BIRTHPLACE OF FATHER. (State or Country). *Don't Know*
12-MAIDEN NAME OF MOTHER. *Don't Know*
13-BIRTHPLACE OF MOTHER. (State or Country). *Don't Know*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Cella Cook*

(Address) *763 Vine St*

NOV 17 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 16*, 192*2*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, au-
topsy or inquiry.)
find that said deceased came to *her* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart
(Duration) yrs. mos. ds. *Don't Know*

CONTRIBUTORY (Secondary) *Don't Know*
(Duration) yrs. mos. ds.
(Signed) *W. H. Gorman* M. D.
(Coroner.)
11-17 192*2* (Address) *1120 Barclay St*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *11/17/22*

20-INTERFARER, ADDRESS *1120 Barclay St*

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69257

CERTIFICATE OF DEATH.

31

D69257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Adams ST., 9 WARD)

2-FULL NAME

(a) RESIDENCE NO. 7 Adams ST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 8 mos. 23 ds.

How long in U. S., if of foreign birth? Life mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Widower

5a If married, widowed, or divorced HUSBAND of late (or) WIFE of Frances Bormuth

6 DATE OF BIRTH (month, day, and year) February 22nd 1880

7 AGE

Years 42

Months 8

Days 23

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Barkeeper for

(b) General nature of industry, business, or establishment in which employed (or employer)

Wm. Drumm

(c) Name of employer

9 BIRTHPLACE (city or town) Balls Blad. (State or country)

10 NAME OF FATHER Joseph A. Bormuth

11 BIRTHPLACE OF FATHER (city or town) Balls Blad. (State or country)

12 MAIDEN NAME OF MOTHER Catherine C. Bormuth

13 BIRTHPLACE OF MOTHER (city or town) Balls Blad. (State or country)

14

Informant (Address)

Mr. Catherine Bormuth
7 Adams

15

NOV 17 1922

ROBERT R. KRAUTER,

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 5 1922

17

I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1922, to Nov 15th, 1922

that I last saw him alive on Nov 15th, 1922

and that death occurred, on the date stated above, at 6:20 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Physical Exam

Signed George H. G. D. D., M. D.

(Address) 401 E. 15th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

Holy Redeemer Cemetery

DATE OF BURIAL

Nov. 18 1922

20 UNDERTAKER

Henry Hoch Son

ADDRESS

1301 E. 15th St.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 5-9-19-H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69258

CERTIFICATE OF DEATH.

D69258

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. *Little Sister of the Poor* ST. *10* WARD)

REGISTERED NO. _____
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mary Hazel*

(a) RESIDENCE. NO. *Frederick Valley Hs.* ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *80* yrs. *—* mos. *—* ds. How long in U. S., if of foreign birth? *80* yrs. *—* mos. *—* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow of*

5a If married, widowed, or divorced HUSBAND of *McLure George Hazel* (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Not Known*

7 AGE *about 82* Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*

10 NAME OF FATHER *Not Known*

11 BIRTHPLACE OF FATHER (city or town) *Not Known* (State or country)

12 MAIDEN NAME OF MOTHER *Not Known*

13 BIRTHPLACE OF MOTHER (city or town) *Not Known* (State or country)

14 Informant *Little Sister of the Poor* (Address) *Frederick Valley Hs.*

15 *NOV 17 1922* ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 16* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *no record* 19*—* to 19*—*

that I last saw h. *Dr* alive on *Nov 12*, 19*22*

and that death occurred, on the date stated above, at *115* a.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (duration) *3* yrs. *—* mos. *—* ds.

CONTRIBUTORY *Acute indigestion* (Secondary) (duration) *1* day, *—* hrs. *—* min.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *P. A. Warner*, M. D.

1133 Valley St, 19*22* (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Holy Redeemer Cemetery *Nov, 20* 19*22*

20 UNDERTAKER ADDRESS

Henry Horch Sr *1301 E Egan St*

Spec. - 1-10-21-M&T-1500 Bks.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69259

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓
D69259

1. PLACE OF DEATH

CITY OF BALTIMORE: No. 1030 Valley ST., 10 WARD)

2. FULL NAME

George. A. Smith

(a) RESIDENCE NO.

1080 Valley

ST., 10 WARD

(Usual place of abode)

Length of residence in city or town where death occurred

84 yrs. 11 mos. 12 ds.

How long in U. S., if of foreign birth?

(If non-resident, give city or town and State)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

the late Catherine Smith

6 DATE OF BIRTH (month, day, and year)

Dec. 5, 1837

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

84

11

12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

Police Officer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore

10 NAME OF FATHER

Mr. Knorr

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Mr. Knorr

12 MAIDEN NAME OF MOTHER

Mr. Knorr

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Mr. Knorr

14

Informant (Address)

Miss. Helen Smith 1030 Valley St.

15

Filed

NOV 17 1922

ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

November 17, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov 17, 1922, to Nov 17, 1922.

that I last saw him alive on Nov 16, 1922.

and that death occurred, on the date stated above, at 5:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Mary F. Voglein, M. D.

11.17.1922 (Address) 1028 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

New Cathedral Cemetery

DATE OF BURIAL

Nov 20, 1922

20 UNDERTAKER

Henry Hock Sr

ADDRESS

1301 E. Eppan

Spec. 1-10-21-MAT 1500 Bks.

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec. 1-10-21-MAT 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69260

CERTIFICATE OF DEATH.

1-001

D69260

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Bond

(a) RESIDENCE NO. 1256 James St.

ST. 21 WARD 4

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)
Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Unknown

6 DATE OF BIRTH (month, day, and year)

June 5, 1869

7 AGE

Years

Months

Days

53

If LESS than
1 day, hrs
or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's Co.,
(State or country) Maryland

10 NAME OF FATHER Lorenzo D. Bond

11 BIRTHPLACE OF FATHER (city or town) St. Mary's
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Matingly

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's
(State or country) Maryland

14 Informant Municipal Hospital Records,
(Address)

15 Filed NOV 17 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15, 1922

17

I HEREBY CERTIFY, That I attended deceased from
November 2, 1922, to November 15, 1922,

that I last saw him alive on November 15, 1922,

and that death occurred, on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. 1 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture

(Signed) Clyde McNeill, M. D.

11/16/22 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

London Park Cemetery

DATE OF BURIAL

Nov 18 1922

20 UNDERTAKER

Robt J Turner Inc 11 Broadway

Information should be carefully supplied. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D69261

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69261

CERTIFICATE OF DEATH.

174-001

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 922 E. Madison ST. 10 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Golden

(a) RESIDENCE NO. 922 E. Madison ST., WARD.

(Usual place of abode) Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX 2e 4 COLOR OR RACE B 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND~~ Alex Golden (See wife of)

6 DATE OF BIRTH (month, day, and year) July 4 - 1857

7 AGE Years 65 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work home (b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Annie Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Correll A. Davis (Address) 1449 N. Carey St

15 Filed NOV 17 1922 ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 14 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 14, 1922, to Nov 14, 1922, that I last saw her alive on Nov 14, 1922, and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. S. Hornstein, M. D.

11/14, 1922 Address) 733 Arisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

20 UNDERTAKER ADDRESS

Nov. 17 1922 302

Spec. 1-10-21-M&T-1500 Bk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69262

CERTIFICATE OF DEATH.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beverly Henry Kitchen

(a) RESIDENCE NO. Washington Av. Mt. Washgtn St. 27 WARD (Intended Res'd't)

(Usual place of abode)

(If non-resident give city, town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? 12 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion A. Kitchen.

6 DATE OF BIRTH (month, day, and year) May-24-1890

7 AGE Years Months Days If LESS than 1 day, hrs. or min. 32 5 23

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mangr. of the Balti-g

(b) General nature of industry, business, or establishment in which employed (or employer) more Branch of the

(c) Name of employer Underwood Typewriter.

9 BIRTHPLACE (city or town) New Brunswick (State or country) Canada

10 NAME OF FATHER William Kitchen

11 BIRTHPLACE OF FATHER (city or town) New Brunswick (State or country) Canada

12 MAIDEN NAME OF MOTHER Mary Estey

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country) not known

14 Informant Mrs. Marion A. Kitchen (wife) (Address) Mt. Washington City.

15 NOV 17 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15th 1922

17 I HEREBY CERTIFY, That I attended deceased from Nov 7th 1922 to Nov 15th 1922.

that I last saw him alive on Nov 15th 1922.

and that death occurred, on the date stated above, at 10:35 p.m.

The CAUSE OF DEATH* was as follows:

Tubercular Infection.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY Acute Appendicitis and (Secondary) Septic Peritonitis (duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov 7th 1922

Was there an autopsy?

What test confirmed diagnosis? Operation and Aut. Finding

(Signed) Richard S. Roberts M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Portland, Maine.

Nov-17-22

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor)

ADDRESS

108 W. NORTH AVE.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69263

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH *1111 Ausquit Street*
CITY OF BALTIMORE (No. *Hehren aged Home* ST. *3* WARD)
2-FULL NAME *Sammy Plitt*
(Residence in Baltimore: No. *131 S Spring Street*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Married*
(Write the word.)

6-DATE OF BIRTH *Unknown*, 1
(Month) (Day) (Year)

7-AGE, *62* — — If LESS than 1 day, yrs. mos. da. hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *None*
(b) General nature of industry, business, or establishment in which employed (or employer), *at aged home*

9-BIRTHPLACE.
(State or Country), *Russia*

10-NAME OF FATHER, *Osua Bernstein*

11-BIRTHPLACE OF FATHER
(State or Country), *Russia*

12-MAIDEN NAME OF MOTHER *Unknown*

13-BIRTHPLACE OF MOTHER *Russia*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Jack Lewis*

(Address) *1439 E. Balto St.*

15-

Filed *NOV 17 1922* *101* *R. B. KRAUTER*
2261 11 NOV Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *11-16*, 19*22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*,
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*,
(Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

apoplexy
(Duration) yrs. mos. da.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. da.

(Signed) *J. H. Miller* M. D.
(Coroner.)

11-16, 19*22* (Address) *508 E. North St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS. TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Hehren Herring Run *11-17*, 19*22*

20-UNDERTAKER, ADDRESS

Jack Lewis 1439 E. Balto St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 MAT 1800 11ks.

D69264

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D69264

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 546 W Biddle

ST. 17 WARD)

2-FULL NAME Elmer E. Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 546 W Biddle

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

1 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Col

5 Single, Married, Widowed,

or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

Bessie Ward

6 DATE OF BIRTH (month, day, and year)

12-12-94

7 AGE

Years

Months

Days

If LESS than

1 day, hrs

or min.

27

11

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or
particular kind of work

Contractor

(b) General nature of industry,
business, or establishment in
which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Crisfield
Somerset Co Md

10 NAME OF FATHER

Saml Ward

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

ma

12 MAIDEN NAME OF MOTHER

Mary Wheatley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

MD

14

Informant
(Address)

Bessie Ward
546 W. Biddle

15

Filed

ROBERT R. KRAUTER,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 16, 1922.

17

I HEREBY CERTIFY, That I attended deceased from
Nov. 12, 1922, to Nov. 15, 1922.

that I last saw him live on Nov. 15, 1922.

and that death occurred, on the date stated above, at 8-20 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis (Acute Pulmonary)

(duration) yrs. 4 mos. ds.

CONTRIBUTORY Asphyxia
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White M.D. M. D.

(Address) 1118 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes,
state (1) Means and Nature of Injury, and (2) whether Accidental,
Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL

Crisfield Md

DATE OF BURIAL

Nov 17 1922

20 UNDERTAKER

Saml W. Chase & Son

ADDRESS

1400 M. St.

Spec. 1-10-21-MAT-1500 Rla.

90

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69265

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Orleans ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Thomas Kane

(a) RESIDENCE NO.

1416 Orleans

ST., _____ WARD _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Kane

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 51 Months _____ Days _____ If LESS than 1 day, _____ hrs. or _____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Mutual Chem. Co.

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER John Stanley

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Hattie Kane (Address) 1416 Orleans St.

15 Filed 2761 in 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 13, 1922

17 I HEREBY CERTIFY, That I attended deceased from Oct. 16, 1922, to Nov. 13, 1922, that I last saw him alive on Nov. 13, 1922, and that death occurred, on the date stated above, at 6:25 p. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

CONTRIBUTORY (Secondary)

18 Where was disease contracted Balto. Md. if not at place of death?

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. C. Brown M.D.

11/13/22 Address 1520 S. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Laurel Hill

DATE OF BURIAL

11/17/22

20 UNDERTAKER Sam'l. T. Dember

ADDRESS 578

W. Biddle St.

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Specs 1-10-21-M&T-1500 R&A.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69266

CERTIFICATE OF DEATH.

101-001

D69266

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 412 N. Fremont ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rawling

(a) RESIDENCE NO. 412 N. Fremont ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 1/2 yrs.

mos.

ds.

How long in U. S., if of foreign birth? yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male

colored

single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto Md

10 NAME OF FATHER

Tom Rawling

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Md

12 MAIDEN NAME OF MOTHER

William Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Md

16 DATE OF DEATH (month, day, and year) Nov 15 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 8, 1922, to Nov 15, 1922

that I last saw him alive on Nov 15, 1922

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumia Acute

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Chest X-ray

(Signed) C. H. Jones, M. D.

Address 712 S. Park St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

1405 Mt Auburn

Nov 18 1922

20 UNDERTAKER

ADDRESS

R. C. Gross 1405 Mt Auburn

15

Filed

19

ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21 M&T—1500 Bks.

D69267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69267

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 675 Vine

ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Jones

(a) RESIDENCE NO. 675 Vine
(Usual place of abode)

ST., 4 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 0 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE Years 50 Months Days If LESS than 1 day, 0 hrs or 0 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

10 NAME OF FATHER William Jenkins

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Carrie askins

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant James Curry
(Address) 675 Vine St

15 Filed NOV 17 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 15 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 14 1922 to Nov 15 1922,

that I last saw him alive on Nov 15 1922

and that death occurred, on the date stated above, at 4:05 P. m.

The CAUSE OF DEATH* was as follows:

Quintuple Coronary Artery Disease

(duration) yrs. 1 mos. 18 ds.

CONTRIBUTOR (Secondary) Dr. Stennin

(duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of Nov 15 1922

Was there an autopsy? No

What test confirmed diagnosis? Autopsy
(Signed) C. D. Stennin M. D.

19 Address 712 S. Sharp Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

National Center

20 UNDERTAKER

R. G. Gross 1405 McElhenny

DATE OF BURIAL

Nov 18

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69268

CERTIFICATE OF DEATH.

161-001 D69268

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 290 20verland

ST.: 27 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. 290 2 - verland

St.: yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE, White 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, Single (Write the word.)

6-DATE OF BIRTH Nov. 15, 1922 (Month) (Day) (Year)

7-AGE, 36 yrs. or min. (If less than 1 day, yrs., mos., ds.)

8-OCCUPATION: (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto.

10-NAME OF FATHER, Mrs. Pittner

11-BIRTHPLACE OF FATHER, (State or Country), Balto.

12-MAIDEN NAME OF MOTHER, Catherine Myers

13-BIRTHPLACE OF MOTHER, (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Pittner

(Address) 290 2 - Overland Ave

15-

Filed NOV 17 1922 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov 15, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922, to Nov 15, 1922, that I saw him alive on Nov 15, 1922, and that death occurred, on the date stated above, at m. The CAUSE OF DEATH* was as follows:

Pneumonia (6 mos.) (Duration) yrs., mos., ds.

CONTRIBUTORY (Secondary) (Duration) yrs., mos., ds.

(Signed) M. D. 11/16, 1922 (Address) 4702 1/2 St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cem DATE OF BURIAL, Nov 17, 1922

20-UNDERTAKER, Margaret H. Hylton 1422 Light St ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Rhs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69269

CERTIFICATE OF DEATH.

185

D69269

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *9* ST., *9* WARD)

2-FULL NAME

(a) RESIDENCE NO. *601 E 41ST ST*

(Usual place of abode)

Length of residence in city or town where death occurred

Life

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced. (write the word)

Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Dec 1898

7 AGE

Years

Months

Days

82

10

24

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

James Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Anne

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Md

14

Informant (Address)

Mrs Anna Leonardt 601 E 41ST ST

15

Filed

NOV 17 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 16 1922

17

I HEREBY CERTIFY, That I attended deceased from *Sept 16, 1920*, to *Nov 16, 1922*, that I last saw him alive on *Nov 16, 1922*

and that death occurred, on the date stated above, at *12:50 PM*

The CAUSE OF DEATH* was as follows:

True met. & x femur

CONTRIBUTORY (Secondary)

(duration)

2 yrs. 2 mos.

ds.

(duration)

yrs.

mos.

ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death?

No

Was there an autopsy?

No

What test confirmed diagnosis?

Sym & Signs

(Signed)

J. J. Sweeney, M. D.

, 19 (Address)

Mer, Hop

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

Baltimore Cemetery

Nov 20 1922

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item entered should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159016
D69270

CERTIFICATE OF DEATH. + 84

D69270

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Robert B. Mathews

(a) RESIDENCE NO.

Anna, Texas.

ST.,

WARD

Anna, Texas
(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. 1 mo. 5

ds. How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Bertha L. Mathews

6 DATE OF BIRTH (month, day, and year)

Dec. 10/1890

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

32 11 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Telegraph operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Texas

10 NAME OF FATHER

Jos. W. Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Texas

12 MAIDEN NAME OF MOTHER

Charannak Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Texas

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 11 1922 to Nov. 16 1922

that I last saw him alive on Nov. 16 1922

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, left cerebellar glioma

(duration) yrs. / mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

at home

Did an operation precede death?

yes

Date of Oct. 14 22

Was there an autopsy?

yes

What test confirmed diagnosis?

operation

(Signed)

J. L. Reichert, M. D.

(Address)

Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Uxbridge

Nov 18 22

20 UNDERTAKER

ADDRESS

H. E. Hughes Ltd

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69271

CERTIFICATE OF DEATH.

103 D69271

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *228 Warren av* ST.; *22* WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Mary Frances Knight*(Residence in Baltimore: No. *228 Warren av.* St.; yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Female* 4-COLOR OR RACE, *White* 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, *Widow*
(Write the word.)

6-DATE OF BIRTH, *Sept 3, 1844*
(Month) (Day) (Year)

7-AGE, *78* yrs., *1* mos., *24* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, *House-wife*
(b) General nature of industry, business, or establishment in which employed (or employer), *Retired*

9-BIRTHPLACE, (State or Country), *Baltimore Md*

10-NAME OF FATHER, *Benjamin Maskey*

11-BIRTHPLACE OF FATHER, (State or Country), *Md*

12-MAIDEN NAME OF MOTHER, *Sarah Hollie*

13-BIRTHPLACE OF MOTHER, (State or Country), *England*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mrs. Blanche Morgan (Daughter)*

(Address) *327 1/2 St. Norfolk Va.*

15-

Filed *Robert J. Harrison* Registrar.

1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 16, 1922*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from *Oct 29, 1922*, to *Nov 16, 1922*, that I saw hu alive on *Nov 15, 1922*, and that death occurred, on the date stated above, at *1452* m. The CAUSE OF DEATH* was as follows:

Cardiac Syncope

(Duration) *about 36 hrs.*

CONTRIBUTORY (Secondary) *Hypertensive congestion of lungs*

(Duration) *about 1 week*

(Signed) *G. L. White* M. D.

Nov 17, 1922 (Address) *905 N. Fulton St.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, *Louisa Park*

DATE OF BURIAL, *Nov 18, 1922*

20-UNDERTAKER, *John F. Denny*

ADDRESS, *715 Light St*

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69272

CERTIFICATE OF DEATH. 118-002

D69272

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Ave & Inf* ST. *77* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. *220 Cedar Ave, Roland Park* ST.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Married*5a If married, widowed, or divorced HUSBAND of (or) WIFE of *Robert C. Ellis*6 DATE OF BIRTH (month, day, and year) *Aug. 25-1897*7 AGE Years *25* Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *house wife*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *N. J.* (State or country)10 NAME OF FATHER *Albert F. Wright*11 BIRTHPLACE OF FATHER (city or town) *Unknown* (State or country)12 MAIDEN NAME OF MOTHER *Mary Gray*13 BIRTHPLACE OF MOTHER (city or town) *Unknown* (State or country)

PARENTS

14 Informant *Robert C. Ellis* (Address) *220 Cedar Ave*

15

Robert F. Harrison, 19

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 17* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Nov. 13*, 19 *22* to *Nov. 17*, 19 *22*.that I last saw her alive on *Nov. 17*, 19 *22*.and that death occurred, on the date stated above, at *6:30 A.M.*

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency extending over a period of years.

(duration) yrs. mos. ds.

CONTRIBUTORY *Intestinal Obstruction* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *11/13/22*Was there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy*(Signed) *Bayetano Papadimitriou*, M. D., 19 (Address) *Church Home and Log*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

WYAL
*Wynnton**11/18* 19 *22*

20 UNDERTAKER

ADDRESS

A. E. Hughes *424 N. Broadway*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Nov 17 1922

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69273 HEALTH DEPARTMENT—CITY OF BALTIMORE D69273

CERTIFICATE OF DEATH. 100-001
1-PLACE OF DEATH
City of BALTIMORE: (No. *Johns Hopkins Hosp* St. *5* Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)
2-FULL NAME *James Evans*
(Residence in Baltimore: No. *430 N. Edegar* St.; yrs. *7* mos. *7* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX <i>Male</i>	4-COLOR OR RACE <i>Black</i>	5-MARITAL STATUS <i>Married</i> (Write the word)
6-DATE OF BIRTH 1..... (Month) (Day) (Year)		
7-AGE <i>24</i> yrs. mos. ds.		If LESS than 1 day, hrs. or min.?
8-OCCUPATION: (a) Trade, profession, or particular kind of work <i>Director</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>974</i>		
9-BIRTHPLACE, (State or Country), <i>N.C.</i>		
PARENTS.	10-NAME OF FATHER, <i>Mr Evans</i>	
	11-BIRTHPLACE OF FATHER, (State or Country), <i>N.C.</i>	
	12-MAIDEN NAME OF MOTHER, <i>Clara James</i>	
	13-BIRTHPLACE OF MOTHER, (State or Country), <i>N.C.</i>	
14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. (Informant) <i>Mr. M. Evans wife</i> (Address) <i>Washington N.C.</i>		

15-
Robert P. Harrison,
Filed *18* 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 15* 192*2*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquiry* (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said *inquiry* (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Lobular Pneumonia
Acute Pericarditis
(Autopsy at Johns Hopkins)
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.
(Signed) *J. H. Patterson* M. D. (Coroner)
11-16 192*2* (Address) *508 E North*
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.
18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death, yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence *North Carolina*
19-PLACE OF BURIAL OR REMOVAL, *Evergreen Cem.* DATE OF BURIAL, *Nov. 18* 192*2*
20-UNDERTAKER, *Wm. J. Y. Locks* ADDRESS *13022 person*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69275

D69275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *503 Fredrick St. Brooklyn* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE: No. *503 Fredrick St. Brooklyn* ST. WARD.(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred *5* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of6 DATE OF BIRTH (month, day, and year) *July 18 - 1917*7 AGE Years Months Days If LESS than
5 *3* *29* I day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer9 BIRTHPLACE (city or town) *Balto.*
(State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) *Balto.*
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) *Balto.*
(State or country)

14

Informant
(Address)*John Paul Riebsam*
*503 Fredrick St. Brooklyn*15 *Robert P. Harrison,* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 17* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from
Nov 12, 19*22*, to *Nov 17*, 19*22*,
that I last saw *him* alive on *Nov 17*, 19*22*,
and that death occurred, on the date stated above, at *7 P.* m.
The CAUSE OF DEATH* was as follows:*Laryngeal dysphagia*(duration) yrs. mos. *1* ds.CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *Harold B. Moore*, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cedar Hill *Nov. 18* 19*22*

20 UNDERTAKER ADDRESS

George L. Schwab *2101 Buck Ave*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCASION is very important. See instructions on back of certificates.

NOV 18 1922

Day 141 Permit Blank

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of QUALITY OF CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69276

CERTIFICATE OF DEATH.

74-001

D69276

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1005 Warden ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Michael J. Maskell

(a) RESIDENCE NO.

1005 Warden ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

M

4 COLOR OR RACE

W

5 Single, Married, Widowed, or Divorced, (write the word)

married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Anna M. Maskell

6 DATE OF BIRTH (month, day, and year)

11/28/1856

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

65

11

18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Church sexton

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Elmira
N. Y.

10 NAME OF FATHER

John Maskell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ireland

12 MAIDEN NAME OF MOTHER

unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ireland

14

Informant
(Address)

Anna M. Maskell

15

Filed

Robert F. Harrison,

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 6 1922 to Nov 16 1922

that I last saw him alive on Nov 16 1922

and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death? 1005 Warden St

Did an operation precede death?

no Date of

Was there an autopsy?

no

What test confirmed diagnosis?

Clinical

(Signed)

James M. Fenton M. D.

11/17 1922 Address

707 E. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

MOYAL

Holy Cross

11/20/ 1922

20 UNDERTAKER

ADDRESS

Wm. Cook, 507 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69277

1-PLACE OF DEATH

City of BALTIMORE: (No. 723 N. 1st St. 4 Ward)

Registered No. C.....

2-FULL NAME

(Residence in Baltimore: No. 723 N. 1st St. 2 yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

male

4-COLOR OR RACE

white

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH

about 1900, 1. (Month) (Day) (Year)

7-AGE

30 yrs., mos., ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Printer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country)

Indianapolis, Indiana

PARENTS.

10-NAME OF FATHER

John Miller

11-BIRTHPLACE OF FATHER, (State or Country)

Ohio

12-MAIDEN NAME OF MOTHER

Glenn Miller

13-BIRTHPLACE OF MOTHER, (State or Country)

Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anville Cal

(Address) Baywater St

15-

Filed

192

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Nov 16, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs., mos., ds.

CONTRIBUTORY (Secondary)

(Duration) yrs., mos., ds.

(Signed) M. D. (Coroner.)

11-17 1922 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs., mos., ds. In the State, yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Anville Cal Nov 18, 1922

20-UNDERTAKER

ADDRESS

J. J. J. & Co 1611 Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69278

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69278

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1552 Woodyea St., 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.....Joseph Simms

(Residence in Baltimore: No. 1552 Woodyea St.; yrs.,..... mos.,..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male 4-COLOR OR RACE, Col 5-Single, Married, Widowed, or Divorced, single
(Write the word)

6-DATE OF BIRTH, April 8 1922
(Month) (Day) (Year)

7-AGE, 7 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Ba Co. Md.

10-NAME OF FATHER, Chas. V. Simms

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Reechel Watts

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. V. Simms

(Address) 1552 Woodyea St.

15-Robert E. Harrison

Filed 1922 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 15 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration)..... mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration)..... yrs. mos. ds.

(Signed) J. J. Hammond M. D.

(Coroner.) Nov. 17 1922 (Address) 2802 Edgemoor Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

Mt Auburn Nov. 17 1922

20-UNDERTAKER, ADDRESS

Edward Ruppel 1462 N. Bay St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69279

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69279

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *Volunteer Hospital* St. *9* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

(Residence in Baltimore: No. *1928 Hope St* St.; yrs. *35* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, *Male* 4-COLOR OR RACE, *White* 5-Single, Married, Widowed, or Divorced, *Married* (Write the word.)

6-DATE OF BIRTH, *June 24* 18*62* (Month) (Day) (Year)

7-AGE, *60* yrs. *4* mos. *10* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work, *Cabinetmaker* (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *Germany*

10-NAME OF FATHER, *Don't know*

11-BIRTHPLACE OF FATHER, (State or Country), *Germany*

12-MAIDEN NAME OF MOTHER, *Don't know*

13-BIRTHPLACE OF MOTHER, (State or Country), *Germany*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *H. G. Loeving*

(Address) *1928 Hope St*

15. *Robert E. Harrison,*

Filed *51322* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 14* 192*3* (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) *Don't know* yrs. mos. ds.

CONTRIBUTORY (Secondary) *Don't know*

(Duration) *Don't know* yrs. mos. ds.

(Signed) *H. G. Loeving* M. D. (Coroner.)

1928 Hope St 192 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

London Park Cemetery *Nov 18* 192*3*

20-UNDERTAKER, ADDRESS

H. M. Roulston *2238 12*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bkn.

D69280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D69280

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S. Strocker ST., 18 WARD)

2-FULL NAME

Alois Leysek

(a) RESIDENCE No.

330 S. Strocker ST.,

WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? 34 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vincencia Leysek

6 DATE OF BIRTH (month, day, and year) unknown 1847

7 AGE Years 75 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED Tailor

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Bohemia (State or country)

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) u (State or country)

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) u (State or country)

14 Informant Frank Horbek (Address) 730 Ramsay st

15 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 17 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 10, 1922, to Nov 17, 1922, that I last saw him alive on Nov 17, 1922, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Asthma - about 2 yrs.
Bronchitis
Pneumonia lobes

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Acute dilatation of heart (Secondary)

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓ no

What test confirmed diagnosis? ✓ no

(Signed) J. J. McLaughlin, M. D. (Address) 11 N. Carey st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Oakhill

DATE OF BURIAL

20 UNDERTAKER

Jirkler & Jirkler

ADDRESS

Eager

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69281

CERTIFICATE OF DEATH.

D69281

1. PLACE OF DEATH

CITY OF BALTIMORE (No. *124 Montebello Terrace* ST. *27* WARD)

2. FULL NAME

(a) RESIDENCE NO.

(Usual place of abode)

Length of residence in city or town where death occurred

58 yrs.

mos.

24

ds.

How long in U. S., if of foreign birth

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Anna Valentine

6 DATE OF BIRTH (month, day, and year)

October 23 1864

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

*58**—**24*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto.

10 NAME OF FATHER

John C. Valentine

11 BIRTHPLACE OF FATHER (city or town) (State or country)

New Jersey

12 MAIDEN NAME OF MOTHER

Sophia Hartzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Pa.

14

Informant

(Address)

*Mrs. Anna Valentine**124 Montebello Terrace*

15

Filed

Robert F. Espartero

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

November 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 1, 1922, to *Nov 17*, 1922

that I last saw him alive on

Nov 13, 1922and that death occurred, on the date stated above, at *10:45* a.m.

The CAUSE OF DEATH* was as follows:

Exhaustion & Tox.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Charles J. ..., M. D.

, 19

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

*Henry Brockman**1301 E. Eager*

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 18 1922

Burial Permit Clerk

MARGIN RESERVED FOR BINDER
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rhs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69282

CERTIFICATE OF DEATH.

124 D69282

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Milcox ST., 9 WARD)

2-FULL NAME

Simon F. Zeller

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

1308 Milcox

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. - mos. - ds. How long in U. S., if of foreign birth? 76 yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of Mary C. Zeller (or WIFE of)

6 DATE OF BIRTH (month, day, and year) Dec. 1st 1842

7 AGE Years 79 Months 11 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Barker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany (State or country)

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mr. Harry F. Zeller (Address) 1308 Milcox St.

15 Filled Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 17th 1922

17 I HEREBY CERTIFY, That I attended deceased from 11:50 A.M. to 1:00 P.M. 1922

that I last saw him alive on 10th of Nov. 1922

and that death occurred, on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Senile Catarrh

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Cemetery Nov. 20, 1922

20 UNDERTAKER

Henry Hooker 1301 E. Bay St.

D69283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164

D69283

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 08 Potapscow Ave. ST. 27 WARD)

2-FULL NAME

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 108 Potapscow Ave. St. 27 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

4-COLOR OR RACE,

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED,
(Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)9-BIRTHPLACE,
(State or Country)

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER
(State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER
(State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov. 9 1922, to Nov. 15, 1922,

that I saw her alive on Nov. 14th, 1922,

and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

Nov. 7th, 1922, (Address) 3524 McMillan St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20-UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69284

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph's Hospital* St. *26* Ward)

Registered No. C.

2-FULL NAME

(Residence in Baltimore: No. *5 E Turley Ave*

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. *44* mos. *11* ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Female

4-COLOR OR RACE

White

5-~~Single~~,
Married,
or Divorced
(Write the word.)

6-DATE OF BIRTH

Dec 6
(Month) (Day)

1897
(Year)

7-AGE

44 yrs. *11* mos. *10* ds.

If LESS than 1 day,
hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer).

At Home

9-BIRTHPLACE
(State or Country).

Balta Md

10-NAME OF FATHER

John Rogers

11-BIRTHPLACE OF FATHER
(State or Country).

Md.

12-MAIDEN NAME OF MOTHER

Lana

13-BIRTHPLACE OF MOTHER
(State or Country).

unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

Andrew Kaufman, Husband
5 E Turley Ave

15.

18-1922

Robert P. Harrison,

192

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Nov 15
(Month) (Day)

1922
(Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquiry*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquiry*
(Inquest, au-

topsy or inquiry.) find that said deceased came to *his* death
on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage - Fractured Skull - Hit by Automobile. Investigation still pending.

(Duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

(Signed) *J. S. Hall* M. D.

(Coroner.)

11-17-1922 (Address) *508 E North Ave*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

For use of undertaker

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Philis Herwig

11/20/22

20-UNDERTAKER

ADDRESS

2016 Orleans St

Orleans St

N. B. - WRITE PLAINLY, WITH UNFADING INK - THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-1-10-21-M&T-1500 Bks.

HEALTH DEPARTMENT-CITY OF BALTIMORE

D69285

CERTIFICATE OF DEATH.

D69285

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 450 N. Pat. St. ST. 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE No. 450 N. Pat. St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced

HUSBAND of

(or) WIFE of

Late Margant Rasch

6 DATE OF BIRTH (month, day, and year) Apr 30 - 41

7 AGE Years 81 Months 6 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

Robert P. Harrison

, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 16 1922

17

I HEREBY CERTIFY, That I attended deceased from

Oct 27, 1922, to Nov 15, 1922,

that I last saw him alive on Nov 15, 1922,

and that death occurred, on the date stated above, at 12:53 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 8 yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Age, unable to walk

(Signed) James D. McCann, M. D.

, 19 (Address) 416 E Northan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

MOVAL

20 UNDER-TAKER

Philip Herwig

DATE OF BURIAL

11/18 1922

ADDRESS 2016

Arden

Serial Permit Disp.

MAINTAIN RESERVED FOR BINDING
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69286

CERTIFICATE OF DEATH.

3/✓ D69286

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Park Hgts. Ave. near Park Lane* ST. *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Karl L. Loose*

(a) RESIDENCE. No. *Park Hgts Ave.* (Usual place of abode)

ST. *17* WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *25* yrs *4* mos. *9* ds. How long in U. S., if of foreign birth? *25* yrs *4* mos. *9* ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *July 8 1897*
7 AGE Years *25* Months *4* Days *9* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work *Salesman*
(b) General nature of industry, business, or establishment in which employed (or employer) *Automobile*
(c) Name of employer *self.*

9 BIRTHPLACE (city or town) *Maryland* (State or country)

10 NAME OF FATHER *W. W. Loose*

11 BIRTHPLACE OF FATHER (city or town) *Maryland.* (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) *Maryland* (State or country)

14 Informant *Mrs. Margarette Chaudron* (Address) *Park Hgts Ave. 707 E. Ave.*

15 Filed *Nov 13 1922* Registrar

Myrla Forest Clark

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *11 17* 19*22*

17 I HEREBY CERTIFY, That I attended deceased from *Sept. 18* 19*22* to *Nov 17* 19*22* that I last saw him alive on *Nov 16* 19*22* and that death occurred, on the date stated above, at *11 A* m. The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis Laryngeal
(duration) *2* yrs. *6* mos. *—* ds.

CONTRIBUTORY *Laryngeal Tuberculosis* (Secondary) (duration) *—* yrs. *4* mos. *—* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date of

Was there an autopsy? *no*

What test confirmed diagnosis? *X-Ray Sputum*
(Signed) *Martin Z. Sloan M.D.*
11.18.1922 (Address) *414 Prof. Bldg.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Graceland Ridge Cem. *Nov. 17 1922*

20 UNDERTAKER ADDRESS

Josiah Syfer *1600 W. North Ave*

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D69287

1-PLACE OF DEATH

City of BALTIMORE: (No. *738 Hartford Ave* St. *10* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Alexander Davis

(Residence in Baltimore: No. *738 Hartford Ave* *65* yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

Male

4-COLOR OR RACE

Black

5-Single, Married, Widowed, or Divorced.

Married
(Write the word.)

6-DATE OF BIRTH

Dec 24 18*67*
(Month) (Day) (Year)

7-AGE

54 yrs. *10* mos. *20* ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

- (a) Trade, profession, or particular kind of work. *Carpenter*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country).

South Carolina

PARENTS.

10-NAME OF FATHER

Alexander Davis

11-BIRTHPLACE OF FATHER, (State or Country).

S. C.

12-MAIDEN NAME OF MOTHER

Katie Dixon

13-BIRTHPLACE OF MOTHER, (State or Country).

S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Katie Davis (Daughter)*

(Address) *Summit St. S. C.*

15-

Robert F. HARRISON,

Filed

102

Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov 14 19*22*
(Month) (Day) (Year)

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest*
(Inquest, au-

inquest find that said deceased came to *death*
topsy or inquiry.)

on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cordian Dilatation

(Admission)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Chronic Hypertension

(Duration) yrs. mos. ds.

(Signed) *J. H. Patten* M. D.

(Coroner.)

11-14 19*22* (Address) *508 E. Lombard*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL,

Ashbury Cemetery

November 18 1922

20-UNDERTAKER

ADDRESS

Mrs. Robert A. Elliot

1725- Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OBITUARY is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D69288

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Devine

(a) RESIDENCE No. Unknown

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1835

7 AGE Years 87 Months -- Days -- If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

10 NAME OF FATHER William Devine

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Robert F. Harrison,
Registrar

Filed NOV 18 1922

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 1922

17 I HEREBY CERTIFY, That I attended deceased from November 1, 1922, to November 15, 1922, that I last saw him alive on November 14, 1922, and that death occurred, on the date stated above, at 2:15 A.M.
The CAUSE OF DEATH* was as follows:

Chronic myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleural effusion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray
(Signed) Philip H. Moore, M. D.

11/16/22 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL Laural Cemetery

DATE OF BURIAL

November 19, 1922

20 UNDERTAKER Mrs. Robert A. Elliott

ADDRESS 1725

Ashland St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69290

D69290

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1001 Harris Alley ST.:

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Bertha Crist

(a) RESIDENCE. NO. 1001 Harris Alley ST.:

WARD.

(Usual place of residence)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred life yrs. — mos. — ds.

How long in U. S., if of foreign birth? life yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27-1922

7 AGE Years 2 Months 19 Days 19 If LESS than 1 day, hrs. — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md. (State or country)

10 NAME OF FATHER Martin

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Stern

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Martin Christ (Address) 1001 Harris Alley

15 Filed Robert F. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 15 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov. 9, 19 22, to Nov. 15, 19 22,

that I last saw him alive on Nov. 9, 19 22,

and that death occurred, on the date stated above, at 8:25 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Infarction

(duration) yrs. — mos. — ds.

CONTRIBUTORY Broncho-Pneumonia (Secondary)

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) R. B. Brown, M. D.

Nov. 15, 19 22 (Address) 3037 Osmond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Swains Creek

Nov. 18 19 22

20 UNDERTAKER

ADDRESS

Stephen J. Frankowski 1001 Harris Alley

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69291

CERTIFICATE OF DEATH.

D69291

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2135 Jefferson ST., 6 WARD)

2-FULL NAME

Shirley M. Jaretsch

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE No.

2135 Jefferson

ST.,

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

Oct 23 1897

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

2524

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Joseph J. Jaretsch

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Balto

12 MAIDEN NAME OF MOTHER

Mary A. Huffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Mrs Mary A. Jaretsch
2135 Jefferson

15

Filed

Robert M. Harrison

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 16 1922

17

HEREBY CERTIFY, That I attended deceased from July 20, 1921, to Nov 16, 1922, that I last saw her alive on Nov 16, 1922, and that death occurred, on the date stated above, at 12:00 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary)

(duration) 4 yrs. 4 mos. 3 ds.(duration) 3 yrs. 3 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Swank, M. D.11/17, 1922 (Address) 413 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Holy Redeemer Nov 20 1922

20 UNDERTAKER

ADDRESS

Leo S. Cook Harford North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1922

Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

69292
D69292

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D69292

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6913 Rutland Ave. 7

WARD)

2-FULL NAME

Charles Edwards

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO.

913 Rutland Ave. 7

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs.

mos.

ds.

How long in U. S. if of foreign birth? 4 yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

male Colored married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Esther Edwards

6 DATE OF BIRTH (month, day, and year)

Unknown

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

36

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

general

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Richmond, Va.

10 NAME OF FATHER

Henry Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Va.

12 MAIDEN NAME OF MOTHER

Emma Sneed

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Va.

14

Informant (Address)

Joseph Bradford 913 Rutland Ave.

15

NOV 19 1922

ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 16, 1922 to Nov. 18, 1922

that I last saw him alive on Nov. 17, 1922

and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

acute febrile

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Balt. Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

clinical

(Signed) J. B. Robinson M. D.

1520 8th Avenue N.E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Richmond Va.

DATE OF BURIAL

November 18, 1922

20 UNDERTAKER

Mrs Robert A Elliott

ADDRESS 1725-

Ashland Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69293

CERTIFICATE OF DEATH

100-001

D69293

1-PLACE OF DEATH

Bayview Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE No.

ST.

WARD

2-FULL NAME

Jacob E. Houck

(a) RESIDENCE No.

1146 Montpelier

ST.

WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs. mos. ds.

How long in U. S., if of foreign birth?

yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

Sex

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Married

5a If married, widowed, or divorced

HUSBAND or (or) WIFE of

Lebanes Houck

6 DATE OF BIRTH (month, day, and year)

? 1884

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

38.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Musicians

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Maryland

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Ido

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Ido.

14

Informant (Address)

Bayview Hospital Baltimore, Md.

15

Filed NOV 19 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 17, 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 4, 1922

to

Nov. 17, 1922

that I last saw him alive on

Nov. 17, 1922

and that death occurred, on the date stated above, at

10 P.M.

The CAUSE OF DEATH* was as follows:

Principles Pneumonia (terminal)

CONTRIBUTORY (Secondary)

(duration)

yrs. mos. ds.

General Paralysis

(duration)

yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Unknown

Did an operation precede death?

No

Date of

Was there an autopsy?

No

What test confirmed diagnosis?

Chemical & Serological

(Signed)

H. G. Smith, M.D.

11/18/22

Address

Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

Woodlawn

Nov 20 1922

20 UNDERTAKER

ADDRESS

William Corb

502 E. North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69294

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69294

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1740 E. Lombard St. Ward)

Registered No. C.

2-FULL NAME

(Residence in Baltimore: No. 1740 E. Lombard St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE

5-Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH

7-AGE

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or Country)

10-NAME OF FATHER

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

NOV 19 1922

ROBERT R. KRAUTER,

Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH

Nov. 18th 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed) Nov 18th 1922 (Address) Curtis Bay

*State the Disease Causing Death, or an Inquest, or Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL

Ashmun Road also 11/19 1922

20-UNDERTAKER, ADDRESS

Jack Lewis 14395 Balch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69295

CERTIFICATE OF DEATH.

D69295

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 224 W. Woodlawn St. 87 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Hertie Berger

(Residence in Baltimore: No. 224 W. Woodlawn Ave. St.; yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male 4-COLOR OR RACE. white 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) S

6-DATE OF BIRTH. April 5, 1922 (Month) (Day) (Year)

7-AGE. 7 yrs., 13 mos., 13 ds. If LESS than 1 day, ...hrs. or...min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Balt. City Md

10-NAME OF FATHER. Jacob

11-BIRTHPLACE OF FATHER. (State or Country). Russian

12-MAIDEN NAME OF MOTHER. Yetta Snyder

13-BIRTHPLACE OF MOTHER. (State or Country). Russian

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E. 13th St

15- NOV 19 1922 ROBERT R. KRAUTER, Registrar.

Filed. 191. Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Nov. 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an inquest, and that said deceased came to death on the day stated above. The CAUSE OF DEATH* was as follows: Convulsions

(Duration) ... yrs. ... mos. ... ds. CONTRIBUTORY (Secondary) ... (Signed) ... (Coroner) ...

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

20-UNDERTAKER. ADDRESS.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rla.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69296

D69296

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Boyd St ST. 18 WARD)

2. FULL NAME

Charles Holmes

(a) RESIDENCE NO.

919 Boyd St

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. 18 mos.

ds. How long in U. S., if of foreign birth?

WARD

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucasian

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1886

7 AGE

36

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Labors

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

va

10 NAME OF FATHER

Orin Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

va

12 MAIDEN NAME OF MOTHER

Paul Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

va

14

Informant (Address)

Harold E. Eason
116 E. Eason St.

15

Filed

19

NOV 19 1922 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 16, 22

17

I HEREBY CERTIFY, That I attended deceased from Nov. 11 - 1922, to November 16, 1922, that I last saw him alive on November 16, 1922, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of lungs

Tuberculosis of lungs

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

Lungs (duration) 1 yrs. 7 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. M. Wernard M. D.

11-17, 1922 Address 708 E. Eason St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

W. M. Wernard

DATE OF BURIAL

Nov 14 1922

20 UNDERTAKER

Harold E. Eason

ADDRESS

116 E. Eason St.

HEALTH DEPARTMENT—CITY OF BALTIMORE 69297

D69297

CERTIFICATE OF DEATH.

D69297

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *14* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Nettie Wilkerson*(a) RESIDENCE, No. *650 Smith St.* ST. *Stevenson, Md.*

(Usual place of abode)

WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

6

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Negress

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

(or) WIFE of *Louis Wilkerson*6 DATE OF BIRTH (month, day, and year) *1886*

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

36

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Stevenson, Md.*10 NAME OF FATHER *Sam Lucas*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Mary Pettou*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*

14

Informant (Address) *Daniel Easton 716 Ba one*

15

NOV 19 1922

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *11/15/22* 19

17

I HEREBY CERTIFY, That I attended deceased from *November 9*, 19*22*, to *November 15*, 19*22*, that I last saw her alive on *November 15*, 19*22*, and that death occurred, on the date stated above, at *10:20 P.m.*

The CAUSE OF DEATH* was as follows:

*Uterine Fibroid**over*

CONTRIBUTORY (Secondary)

(duration) *3* yrs. mos. ds.*Paralytic ileus*(duration) yrs. mos. ds. *3*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *yes* Date of *11/11/22*

Was there an autopsy?

What test confirmed diagnosis? *Clinical symptoms*(Signed) *Anthony V. Buchanan*, M. D., 19 (Address) *University Hospital*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*St. Auburn Bur**Nov 18 1922*

20 UNDERTAKER

ADDRESS *716**Daniel Easton**Ba one*

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

No other history.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69298

CERTIFICATE OF DEATH.

40 D69298

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 1118 N. Carey

ST. 16 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Catherine Mason

(Residence in Baltimore: No. 1118 N. Carey

St. 36 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

Cul

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH,

1871 (Month) (Day) (Year)

7-AGE,

51 yrs. mos. ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:

(a) Trade, profession, or particular kind of work. Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

Md

10-NAME OF FATHER,

Josiah Reid

11-BIRTHPLACE OF FATHER (State or Country),

Md

12-MAIDEN NAME OF MOTHER

Rebecca Barber

13-BIRTHPLACE OF MOTHER (State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

Annie Smith

(Address)

1118 N. Carey

15-

Filed

191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov-18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from

Nov-2, 1922, to Nov-17, 1922,

that I saw her alive on Nov-17, 1922,

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH was as follows:

Acute Bronchitis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. F. Coleman, M. D.

Nov-18, 1922 (Address) 9038 N. Carey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

New Catholic

DATE OF BURIAL,

Nov 19, 1922

20-UNDERTAKER

Daniel Easton

ADDRESS

916 N. Carey

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work, and also (b) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of*

lungs, meninges, peritoneum, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*; etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Broncho pneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hamorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced)*, whether death is directly or indirectly due to the same.

D69299 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 40 D69299

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *12* WARD)

2-FULL NAME

Mattie Palmer

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *2306 Hunter Street* ST. *12* WARD.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs. *1*mos. *15*ds. *15*

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *1900*

7 AGE

Years *22*

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Virginia

10 NAME OF FATHER

Jerry Palmer

PARENTS

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

Virginia

14

Informant (Address)

Daniel Easton 916 Pa ave

15

NOV 19 1922

ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 17* 19*22*

17

I HEREBY CERTIFY, That I attended deceased from *Nov. 14*, 19*22*, to *Nov. 17*, 19*22*.that I last saw her alive on *November 17*, 19*22*.and that death occurred, on the date stated above, at *4-10 A.m.*

The CAUSE OF DEATH* was as follows:

Pneumonia - (Lobar.)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Peritonitis(duration) yrs. mos. ds. *21*

18 Where was disease contracted

if not at place of death?

Did an operation precede death? *Yes* Date of *Nov. 14, 22*Was there an autopsy? *Yes*

What test confirmed diagnosis?

Autopsy

(Signed)

Wm. J. Fulton

M. D.

, 19 (Address)

University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

*Int. Auburn Cem**Nov 21 1922*

20 UNDERTAKER

*Daniel Easton*ADDRESS *916 Pa ave*

Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69300

CERTIFICATE OF DEATH.

D69300

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *University Hospital* ST. *11* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME *Mrs. Annie Rudy*(a) RESIDENCE. NO. *409 E. Preston St.* ST. _____ WARD. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *10* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widow.*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of _____

6 DATE OF BIRTH (month, day, and year) *Unknown*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *65*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *House wife.*

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) (State or country) *Maryland.*10 NAME OF FATHER *Edward Dean*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Maryland.*12 MAIDEN NAME OF MOTHER *Mary Ball*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Maryland*14 Informant *Mrs. Annie Rudy* (Address) *409 E. Preston St.*15 Filed *NOV 19 1922* *ROBERT R. KRAUTER* Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 17, 1922*17 I HEREBY CERTIFY, That I attended deceased from *Nov. 8, 1922* to *Nov. 17, 1922*, that I last saw him alive on *Nov. 17, 1922*, and that death occurred, on the date stated above, at *8.50 P. m.*

The CAUSE OF DEATH* was as follows:

Post-operative shock

CONTRIBUTORY (Secondary)

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? *Yes* Date of *Nov. 14, 1922*Was there an autopsy? *No.*What test confirmed diagnosis? *Operation.* (Signed) *J. Willis Guyton* M. D. , 19 (Address) *University Hospital.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Brimswick Md. *11-20 1922*

20 UNDERTAKER

C & B Harle *115 E. West St.*

EVERY ITEM OF INFORMATION SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE STATED EXACTLY. PHYSICIANS SHOULD STATE CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT. SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*;

Whooping cough; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

*Adhesion of the Intes-
tinal tract.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69301

CERTIFICATE OF DEATH.

101-001 D69301

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 112 E. 25th

ST. 17

WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

William T. Harrington

(a) RESIDENCE. No. 112 E. 25th

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE of

Catherine M. Harrington

6 DATE OF BIRTH (month, day, and year)

July 11-1867

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

60

8

7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

Va

10 NAME OF FATHER

Timothy Harrington

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

Ireland

12 MAIDEN NAME OF MOTHER

Mary J. Sullivan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Ireland

14 Informant

(Address)

Catherine M. Harrington
112 E. 25th St.

15 Filed

19

ROBERT R. KRAUTER

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov. 18th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 13, 1922, to Nov. 17, 1922.

that I last saw him alive on Nov. 17, 1922.

and that death occurred, on the date stated above, at 2:40 A. M.

The CAUSE OF DEATH* was as follows:

Gastric pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green, M. D.

11-19-1922 (Address) 120 Reisinger St

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

Cathedral Cemetery

11/22 1922

20 UNDERTAKER

ADDRESS

Chas. J. Wawer & Son 118 W. Mt. Royal Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003

D69302

PLACE OF DEATH *Mad General Hospital*

CITY OF BALTIMORE (No. *613 Colorado Ave* Twp *7*) WARD)

*FULL NAME *John Burrwell Williams*

(Residence in Baltimore: No. *613 Colorado Ave Twp*)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., *7* mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. *Male* 4-COLOR OR RACE, *White* 5-SINGLE, *Single*
MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, *April 10*, 19*12*
(Month) (Day) (Year)

7-AGE, *10* yrs., *7* mos., *7* ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. *School Boy*
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), *New York*

10-NAME OF FATHER, *Louis B. Williams*

11-BIRTHPLACE OF FATHER (State or Country), *Washington D. C.*

12-MAIDEN NAME OF MOTHER, *Mary B. Brainard*

13-BIRTHPLACE OF MOTHER (State or Country), *Pa*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Mary B. Boyle Mother*

(Address) *613 Colorado Ave Twp*

15-

Filed, 191.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov. 17*, 19*22*
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest*
(Inquest, autopsy or inquiry.)

thereon, and from the evidence obtained by said *inquest*
(Inquest, autopsy or inquiry.) find that said deceased came to *this* death on the day stated above.

The CAUSE OF DEATH* was as follows:
Perforation of Liver

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) *Automobile accident*

(Duration) ... yrs. ... mos. ... ds.

(Signed) *J. T. Hennessy* M. D.
(Coroner.)

(Address) *280 E. Baltimore*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death, ... yrs. ... mos. ... ds. In the State, ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, *Woodlawn Cemetery Nov. 20*, 19*22*

20-UNDERTAKER, ADDRESS *Henry Jenkins & Son 8 Orchard St. Baltimore*

MAJOR RECORDS SECTION
N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

69303
90 D69303

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 Gale Ave ST. 20 WARD)

2-FULL NAME

(a) RESIDENCE NO. 321 Gale Ave

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds.

ST.

WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Chas F Eichner

6 DATE OF BIRTH (month, day, and year)

Nov. 18, 1845

7 AGE

76

Years

Months

11

Days

29

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Catonsville Md.

10 NAME OF FATHER

Christian Pehlmann

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant

(Address)

Louise Schaar

321 Gale Ave

15

Filed

226161 AON

ROBERT R. KRAUTER

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 17 1922

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1922, to Nov 17, 1922

that I last saw him alive on

Nov 17, 1922

and that death occurred, on the date stated above, at

4.10 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Myocardial Infarction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Valv. Dis. of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)

Charles W. Waukear

M. D.

19

(Address)

Catonsville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park

DATE OF BURIAL

Nov 20 1922

20 UNDERTAKER

Chas. W. Dill

ADDRESS

3109 Fredk. Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D69304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69304

1-PLACE OF DEATH

City of BALTIMORE: (No. 18)

2-FULL NAME

(Residence in Baltimore: No. 18)

CERTIFICATE OF DEATH

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX, Female
4-COLOR OR RACE, white
5-Single, Married, Widowed, or Divorced, Single

6-DATE OF BIRTH, July 14, 1918
(Month) (Day) (Year)

7-AGE, 5 yrs., 4 mos., 2 ds.
If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, none
(b) General nature of industry, business, or establishment in which employed (or employer),

9-BIRTHPLACE, (State or Country), Baltimore Md.

10-NAME OF FATHER, Frank J. Braun

11-BIRTHPLACE OF FATHER, (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Bertha McLaughlin

13-BIRTHPLACE OF MOTHER, (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bertha Braun

(Address) 3136 Stafford St.

15-NOV 19 1922

Filed 1922 ROBERT R. KRAUTER, Registrar

Burial Permit

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Nov 16, 1922
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

Thereon and from the evidence obtained by said inquest, autopsy or inquiry, I find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto Accident
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Robert R. Krauter, M. D.

(Address) 3136 Bradford

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, suicidal, or homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death, yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

New Cathedral Cemetery Nov 20, 1922

20-UNDERTAKER, ADDRESS

Has. W. Dill, 3109 Fredk. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69305
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

161-001 D69305
REGISTERED NO. C

CITY OF BALTIMORE: (No. 425 N. Caroline ST. 6 WARD)

2-FULL NAME Marceline Mitchell

(Residence in Baltimore: No. 425 N. Caroline St. yrs. mos. 19 ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female 4-COLOR OR RACE, Col. 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct. 31, Tuesday, 1922 (Month) (Day) (Year)

7-AGE, yrs. mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. nil (b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), 425 N. Caroline St, Balto. Md.

10-NAME OF FATHER, J. A. D. Masters

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Marceline Mitchell

13-BIRTHPLACE OF MOTHER (State or Country), Cambridge Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marceline Mitchell

(Address) 425 N. Caroline St.

15-NOV 19 1922

ROBERT R. KRAUTER,

Filed 191 Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Nov. 18, 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 31, 1922, to Nov. 18, 1922, that I saw her alive on 184 da. Nov. 1922, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Premature Birth

(Duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. Mayfield Boyle M. D.

Nov. 19, 1922 (Address) 425 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

Laurel Cemetery Nov. 19, 1922

20-UNDERTAKER ADDRESS

J. H. Rochester 1413 Jefferson St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69306

CERTIFICATE OF DEATH.

69306
D69306

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *St. Agnes Hosp.* ST. *25* WARD)

2-FULL NAME

(a) RESIDENCE NO. *St. Agnes Hosp.* ST. *25* WARD *Phila Pa*

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Information (Address)

15

Filed

NOV 19 1922

ROBERT R. KRAUTER,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17

HEREBY CERTIFY, That I attended deceased from *Nov 15*, 19*22* to *Nov 17*, 19*22* that I last saw him alive on *Nov 17*, 19*22* and that death occurred, on the date stated above, at *4:30 p.m.*

The CAUSE OF DEATH* was as follows:

Chr. Nephritis - Arteriosclerosis Myocardial Insufficiency - Hypertension

several yrs. (duration) yrs. mos. ds.

CONTRIBUTORY *Broncho-pneumonia* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Home*

Did an operation precede death? *No* Date of

Was there an autopsy? *No*

What test confirmed diagnosis? *Clinical*

(Signed) *W.C. Caldwell*, M. D.

, 19 (Address) *St. Agnes Hosp.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Bermantown Pa
Martin Huber Sons 1821 W. North

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69307

CERTIFICATE OF DEATH.

D69307

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *3700 North Road* ST.: *15* WARD)

2-FULL NAME

Margaret A. Campbell

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. NO. *3700 North Road* ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *2* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Widowed*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *about 1860*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *about 62*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *none*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *Ireland*10 NAME OF FATHER *unknown*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *unknown*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) *Mrs. L. Smith 3700 North Road*15 Filed *NOV 19 1922* 19 *ROBERT B. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 18* 19*22*17 I HEREBY CERTIFY, That I attended deceased from *Oct 1*, 19*22*, to *Nov 18*, 19*22*.that I last saw her alive on *Nov 18*, 19*22*.and that death occurred, on the date stated above, at *3 P* m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis.
Chronic interstitial nephritis(duration) *7* yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis(duration) *1* mas. *18* ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? *no* Date ofWas there an autopsy? *no*What test confirmed diagnosis? *physical*
(Signed) *Walter S. Abbott*, M. D.*Nov 18*, 19*22* (Address) *2220 Harrison*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Philadelphia Pa. *11/21* 19*22*

20 UNDERTAKER ADDRESS

H. E. Hughes 424 N. Broadway

Physicians should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE 69308

D69308

CERTIFICATE OF DEATH. 122-001 D69308

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2019 Orleans ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE NO. 2019 Orleans

ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred

07 yrs.

mos.

ds.

How long in U. S., if of foreign birth?

(If non-resident give city or town and State)

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced, (write the word)

Married

5 If married, widowed, or divorced HUSBAND of (or) WIFE of

Gene Minkler

6 DATE OF BIRTH (month, day, and year)

Apr 2 - 1857

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

11

7

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Germany

10 NAME OF FATHER

John Engelman

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Dorothy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Germany

14

Informant (Address)

Gene Engelman

15

Filed

NOV 19 1922

ROBERT R. KRAUTER

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

Nov 16 1922

17

I HEREBY CERTIFY, That I attended deceased from October 1922, to Nov 16 1922

that I last saw him alive on Nov 16 1922

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Corrosion of Liver

over

(duration) 6 yrs. mos. ds.

CONTRIBUTORY Pulmonary Emphysema

(Secondary) (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Guoyor M. D.

1922 Address 4510 E. 1st St. No

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Holy Redeemer Church

20 UNDERTAKER

J. D. Ulrich

DATE OF BURIAL

Nov 20 1922

ADDRESS

2019 Orleans

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Assn.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of

"Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS
BY PHYSICIAN.

Alcoholic.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 - MATT. 1500 lka.

D69309

159397/69309

HEALTH DEPARTMENT—CITY OF BALTIMORE

69309

CERTIFICATE OF DEATH.

X 90

D69309

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth C. Cooper

(a) RESIDENCE NO. Hinton, W. Va. ST., 7 WARD

(Usual place of abode) Length of residence in city or town where death occurred 3 weeks mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced Married (or) WIFE of Dr. O. C. Cooper

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1870

7 AGE Years 52 Months 11 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Tennessee

10 NAME OF FATHER Robert J. Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rachel Coates

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Commonwealth of Canada

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 NOV 20 1922 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 19 22

17 I HEREBY CERTIFY, That I attended deceased from Oct. 31, 19 22, to Nov. 18, 19 22, that I last saw her alive on Nov. 18, 19 22, and that death occurred, on the date stated above, at 5:40 P.m.

The CAUSE OF DEATH* was as follows:
hypertension; myocardial insufficiency.

(duration) 2 yrs. 2 mos. 1 ds.
CONTRIBUTORY (Secondary) Cerebral hemorrhage
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) W. H. Herman, M. D.

11-19, 19 22 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL HINTON W. VA DATE OF BURIAL 11-18-22

20 UNDERTAKER H. E. HUGHES ADDRESS 424 N. BROADWAY

D69310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓

D69310

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103-East 23rd ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John O. Townsend(a) RESIDENCE. No. 103-East 23rd ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) MarriedIf married, widowed, or divorced HUSBAND of (or) WIFE of Grace Townsend6 DATE OF BIRTH (month, day, and year) Sept 24/18487 AGE Years 74 Months Days 11 LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland10 NAME OF FATHER Geo C. Townsend11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland12 MAIDEN NAME OF MOTHER Esther Holland13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland14 Informant Grace M. Townsend (Address) 103-E-23rd

15 NOV 20 1922 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 18 192217 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1916, to November 18, 1922, that I last saw him alive on November 18, 1922, and that death occurred, on the date stated above, at 8:40 P. m. The CAUSE OF DEATH* was as follows:Chronic Interstitial Nephritis(duration) 10 yrs. mos. ds.CONTRIBUTORY Cerebral softening (Secondary)(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date ofWas there an autopsy? NoWhat test confirmed diagnosis? Clinical examination(Signed) George M. Burke, M. D.11/19, 1922 (Address) 2435 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Greenmount Cemetery 11/20 1922

20 UNDERTAKER

Wm Cook

ADDRESS

502 E. North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69311

CERTIFICATE OF DEATH.

D69311

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2641 Edmondson Ave ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

Edward Lange, Jr

(a) RESIDENCE. NO.

2641 Edmondson Ave

ST.

WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 10 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Married

5a If married, widowed, or divorced

HUSBAND of
(or) WIFE ofMary Lange

6 DATE OF BIRTH (month, day, and year)

Jan-8-1888

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.341010

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

None9 BIRTHPLACE (city or town)
(State or country)Baltimore
Md.

10 NAME OF FATHER

Edward Lange

11 BIRTHPLACE OF FATHER (city or town)

Baltimore

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Anna Rice

13 BIRTHPLACE OF MOTHER (city or town)

Baltimore

(State or country)

Md.

14

Informant
(Address)Adelaide Harris
2641 Edmondson Ave

15

Filed

19

NOV 20 1922

ROBERT R. KRAUS Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) November 18 1922

17

I HEREBY CERTIFY, That I attended deceased from

October 16, 1922, to November 18, 1922,that I last saw him alive on November 18, 1922,and that death occurred, on the date stated above, at 12:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis(duration) 10 yrs. — mos. — ds.CONTRIBUTORY
(Secondary)(duration) — yrs. — mos. — ds.

18 Where was disease contracted

if not at place of death?

unknownDid an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Sputum(Signed) Chester Poland, M. D.1-18-1924 Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Lenox Park Nov 20 1922

20 UNDERTAKER

ADDRESS

William Cox 5026 North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Baltimore, Md., Dec. 1, 1922.

I do hereby make oath that the duration of disease given as the Cause of Death on Baltimore City Health Department Certificate of Death #D-69311, as 10 years, is not correct, same should have been recorded as "Unknown".

Chester Riland, Jr.
Physician.

Subscribed and sworn to before me this first day of December, 1922.

Reed Gaither
Notary Public.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19-H. P. Co.-1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69312

CERTIFICATE OF DEATH.

74-001

D69312

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Little Sisters of the Poor*, ST.: *10* WARD)

2-FULL NAME *Eliza Welsh*

(a) RESIDENCE. NO. *Preston Valley Ho.* ST. WARD.

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred *Life* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *22 Oct. 1852*

7 AGE Years *70* Months Days *28* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *Dressmaker*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Md.*

10 NAME OF FATHER *John Welsh*

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER *Ellen Roche*

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant *Sister Florence* (Address) *Preston Valley Ho.*

15 *NOV 20 1922* *ROBERT R. KRAUTER* Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov 18 1922*

17 I HEREBY CERTIFY, That I attended deceased from *11/18/22* to *11/18/22*

that I last saw *her* alive on *Nov 17*, 19*22*

and that death occurred, on the date stated above, at *5.30 a.m.*

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) *Coron*

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) *F. G. Warner*, M. D.

(Address) *1133 Valley H*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Cathedral *Nov. 20 1922*

20 UNDERTAKER ADDRESS

H. C. Wiedefeld 917 Grumm

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PRELIMINARY STATEMENT. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Form 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D69313

CERTIFICATE OF DEATH.

90

D69313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

2-FULL NAME Joseph H. Redding

(a) RESIDENCE. NO. Ret Hope Retreat - Baltimore ST. 28 WARD.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 2 yrs. 6 mos. 0 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of Mrs Redding (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21-1837

7 AGE Years Months Days If LESS than 1 day, hrs. or min.
abt 85 0 0 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer

9 BIRTHPLACE (city or town) Phila Pa (State or country)

10 NAME OF FATHER Phillip Redding

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Stron

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Germany

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Retreat

15 Filed NOV 20 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19 19 22

17 I HEREBY CERTIFY, That I attended deceased from May 5-1920 19 19 to Nov 19 19 22

that I last saw him alive on Nov 19 19 22

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

abt (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY mania senile (Secondary)

abt (duration) 2 yrs. 1/2 mos. 0 ds.

18 Where was disease contracted Gettysburg Pa if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Gettysburg Pa Nov 20 19 22

20 UNDERTAKER ADDRESS

W. J. Lickner North Perry

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69314

CERTIFICATE OF DEATH.

D69314

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1439 W. Lafayette Ave. ST. 16 WARD)

2-FULL NAME Wm B. Bealmeier

(a) RESIDENCE NO. 1439 W. Lafayette Ave. ST. 16 WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. 0 mos. 0 ds.REGISTERED NO. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male4 COLOR OR RACE White5 Single, Married, Widowed, or Divorced, (write the word) Married5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Brewer Bealmeier6 DATE OF BIRTH (month, day, and year) Oct 4-1850

7 AGE

Years 72Months 1Days 14

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD10 NAME OF FATHER Samuel Bealmeier11 BIRTHPLACE OF FATHER (city or town) (State or country) Ma12 MAIDEN NAME OF MOTHER Ann Brewer13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14

Informant (Address) Elizabeth Brewer
1439 W. Lafayette Ave.

15

Filed Nov 20 1922

19

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 19 22

17

I HEREBY CERTIFY, That I attended deceased from July 1, 19 22, to Nov 18, 19 22.that I last saw him alive on Nov 18, 19 22.and that death occurred, on the date stated above, at 8:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis
arterio-sclerosis(duration) 8 yrs. — mos. — ds.CONTRIBUTORY (Secondary) General Hemorrhage(duration) — yrs. — mos. 1 ds.18 Where was disease contracted if not at place of death? —Did an operation precede death? no Date of —Was there an autopsy? noWhat test confirmed diagnosis? Urinary(Signed) Robert R. Krauter, M. D., 19 22 (Address) 1227 W. Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-
MOVAL Laurel MountDATE OF BURIAL Nov 24 192220 UNDERTAKER W. G. RichmondADDRESS Water

16869
Apes. 1-10-21 M&T 1500 Hhs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69315

CERTIFICATE OF DEATH.

D69315

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3920 Mt. Pleasant Ave. ST. 26 WARD)

2-FULL NAME Louisa Guerrero.

(a) RESIDENCE NO. 3920 Mt. Pleasant Ave. ST. 26 WARD

(Usual place of abode)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13-1914

7 AGE Years 8 Months 4 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attended

(b) General nature of industry, business, or establishment in which employed (or employer) school.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

10 NAME OF FATHER Alfred Guerrero.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Louisa Guentherberger.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland.

14 Informant Alfred Guerrero. (Address) 3920 Mt. Pleasant Ave.

15 Filed NOV 20 1922 ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18 1922

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Nov 18, 1922, that I last saw her alive on Nov 16, 1922

and that death occurred, on the date stated above, at 12.00 G. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Sequel to Chorea)

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Dilated heart

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) M. J. M. Avey M. D.

1922 (Address) 839 S. Edmond Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cath. Lawn Cem.

DATE OF BURIAL

Nov. 21 1922

20 UNDERTAKER

Lilly & Zick

ADDRESS

403 S. North

Burial Permit Clerk.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE D69316

D69316

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. *St. Joseph's Hosp.* St. *26* Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME *Frances Provenzano*

(Residence in Baltimore: No. *3924 Claremont St.* St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX *Female* 4-COLOR OR RACE *White* 5-*Single*, married, *Widowed* or Divorced, (Write the word.)

6-DATE OF BIRTH. *Aug 10* 1916 (Month) (Day) (Year)

7-AGE, *6* yrs. *3* mos. *7* ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work *Child* (b) General nature of industry, business, or establishment in which employed (or employer) *at home*

9-BIRTHPLACE, (State or Country). *Balt. Md.*

10-NAME OF FATHER, *Frances Provenzano*

11-BIRTHPLACE OF FATHER, (State or Country). *Italy*

12-MAIDEN NAME OF MOTHER, *Agatha Rotundo*

13-BIRTHPLACE OF MOTHER, (State or Country). *Italy*

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) *Agatha Rotundo*

(Address) *3924 Claremont St.*

15-

Filed *NOV 20 1922* 1922 *ROBERT R. KRAUTER* Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, *Nov 17* 1922 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an *inquest* (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said *inquest* (Inquest, autopsy or inquiry.) find that said deceased came to *his* death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental - 2nd degree burns over 75 surface body. (Clothes caught fire from bonfire on lot adjacent to home while at play.)

CONTRIBUTORY (Secondary) *play* (Duration) *11-19-1922* yrs. *3* mos. *6* ds. (Signed) *J. St. O'Brien* M. D. (Coroner.) (Address) *508 E. North Ave.*

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, *St. Vincents* DATE OF BURIAL, *Nov. 20* 1922

20-UNDERTAKER, *Lilly & Ziehl* ADDRESS *403 S. Wolf St.*

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69317

CERTIFICATE OF DEATH.

D69317

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 W. West ST. 23 WARD)2-FULL NAME Emma A. Keller(a) RESIDENCE NO. 23 W. West

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Keller6 DATE OF BIRTH (month, day, and year) April 24, 18547 AGE Years 68 Months 6 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties(b) General nature of industry, business, or establishment in which employed (or employer) (c) Name of employer 9 BIRTHPLACE (city or town) (State or country) Baltimore Md.10 NAME OF FATHER Charles Keller11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany12 MAIDEN NAME OF MOTHER Unknown13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant (Address) Lottie Keller
23 W. West St.

15

Filed NOV 20 1922ROBERT R. KRAUTER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17, 192217 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1922 to Nov 17, 1922that I last saw him alive on Nov 17, 1922and that death occurred, on the date stated above, at 4:45 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Regeneration(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 1 mos. ds.18 Where was disease contracted if not at place of death? Did an operation precede death? Date of Was there an autopsy? What test confirmed diagnosis? (Signed) M. D.19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

DATE OF BURIAL

London Park Nov. 20, 1922

20 UNDERTAKER

ADDRESS

Mr. J. H. Smith

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

069318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C

90 D69318

1-PLACE OF DEATH

CITY OF BALTIMORE (No.

2-FULL NAME

(Residence in Baltimore: No.

ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH,

7-AGE,

If LESS than 1 day,

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country),

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (State or Country)

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country)

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15-

Filed

NOV 20 1922

101

ROBERT R. KRAUTER,

Burial Permit

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH,

17-

I HEREBY CERTIFY, That I took charge of the

remains described above, held an

thereon and from the evidence obtained by sal

find that said deceased came to death

on the day stated above.

The CAUSE OF DEATH* was as follows:

CONTRIBUTORY (Secondary)

(Signed)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death... yrs. ... mos. ... ds. In the ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL,

20-UNDERTAKER

ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69319

CERTIFICATE OF DEATH.

D69319

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 N. Pulaski St. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME Ruth E. Wentworth

(a) RESIDENCE No. 21 E. Henrietta St.

ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard C. Wentworth

6 DATE OF BIRTH (month, day, and year) Mar. 11 1905

7 AGE Years Months Days If LESS than 1 day, hrs or min. 17 8 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

10 NAME OF FATHER William T. Cottingham

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Lula M. Todd

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant William T. Cottingham (Address) 1908 Pulaski st.

15 NOV 20 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 18th 192217 I HEREBY CERTIFY, That I attended the deceased from Nov. 14th 1922, to Nov. 18th 1922, that I last saw her alive on Nov. 19th 1922,and that death occurred, on the date stated above, at 3⁰⁰ A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Pulminating type)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At 21 E. Henrietta St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Physical Findings (Signed) Harry Heibel 11/19, 1922 (Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

Loudon Park Cem.

DATE OF BURIAL

11/21 1922

20 UNDERTAKER

L. Hew M. Gully

ADDRESS

130 E. Fort

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B. — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. — 1-10-21 — M&T — 1500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69322

CERTIFICATE OF DEATH

D69322

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 Hafer St.

ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius L. Goddard

(a) RESIDENCE NO. 29 Hafer St.

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

3 wks.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Male

White

Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 13" 1880

7 AGE

Years

Months

Days

If LESS than 1 day: hrs. or min.

22

3

6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's Co. Md. (State or country)

10 NAME OF FATHER George R. Goddard

11 BIRTHPLACE OF FATHER (city or town) St. Mary's Co. Md. (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Norris

13 BIRTHPLACE OF MOTHER (city or town) St. Marys Co. Md. (State or country)

14 Informant G. R. Goddard (Address) St. Mary's City, Md.

15 NOV 20 1922

ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19" 19 22

17

I HEREBY CERTIFY, That I attended deceased from Nov 9, 1922, to Nov 19, 1922.

that I last saw him alive on Nov 9, 1922, at 9 20 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Bronchitis Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Anger, Anger, Anger

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Cook, M. D.

11/20/22 Address 1227 Columbia Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Mary's City Md. Nov 20 1922

20 UNDERTAKER

ADDRESS

J. B. Cook

1003 W. Baltimore

D69324

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69324

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *1203 Angyle Ave* ST. *17* WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

James K. Brown

(a) RESIDENCE

No. *1203 Angyle Ave* ST. *17* WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred *37* yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *Colored* 5 Single, Married, Widowed, or Divorced (write the word) *Widow*

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *February 1847*7 AGE Years Months Days If LESS than 1 day, hrs. or min. *75*

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) *St. Mary's Co. Md*10 NAME OF FATHER *Liddell Jackson*11 BIRTHPLACE OF FATHER (city or town) (State or country) *Md*12 MAIDEN NAME OF MOTHER *Leroy Miles*13 BIRTHPLACE OF MOTHER (city or town) (State or country) *Md*14 Informant (Address) *James K. Brown 1203 Angyle Ave*15 Filed *20 1922* 19 *ROBERT R. KRAUTER* Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 18* 19 *22*

17

I HEREBY CERTIFY, That I attended deceased from *Oct 23*, 19 *22*, to *Nov. 18*, 19 *22*, that I last saw him alive on *Nov. 18*, 19 *22*, and that death occurred, on the date stated above, at *3:35 a.m.*

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy(duration) yrs. mos. ds. *27*

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds. *1*

18 Where was disease contracted if not at place of death?

Did an operation precede death? *No* Date ofWas there an autopsy? *No*What test confirmed diagnosis? *Physical*(Signed) *Edward J. Mearns*, M. D.11/20/22 (Address) *1228 David Hill Ave*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS *578**James K. Brown 1203 Angyle Ave**H. A. W.*

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D69325

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 N. Biddle St. ST. 17 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME

(a) RESIDENCE. No. 532 N. Biddle ST.

(Usual place of abode)

WARD.

Length of residence in city or town where death occurred 42 yrs. mos. ds.

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced (write the word)

Male

Colored

Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

1860

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14

Informant

(Address)

15

Filed

19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 17 - 1922

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1922 to Nov. 17, 1922 that I last saw him live on Nov. 17, 1922 and that death occurred, on the date stated above, at 1:25 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

CONTRIBUTORY (Secondary) Arterio-sclerosis

18 Where was disease contracted if not at place of death?

Did an operation precede death?

Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. McElroy M. D. 11/26 1922 Address 1230 South Huron

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

Physicians should state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 20 1922

ROBERT R. KRAUTER

Burial Permit Clerk

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. See instructions on back of certificates.

Spec. 1-10-21 M.B.T. 1800 Ills.

D69326

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69326

CERTIFICATE OF DEATH.

11-001

1. PLACE OF DEATH

CITY OF BALTIMORE: (Nov 1922) JOHNS HOPKINS HOSPITAL ST. 8 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME

Owen O'Rourke

(a) RESIDENCE NO.

2409 E. Chase St

ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred

life

mos.

ds.

How long in U. S., if of foreign birth?

ys.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

April 23, 1922

7 AGE

Years

Months

Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

Baltimore Md

10 NAME OF FATHER

Hugh O'Rourke

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Tex

12 MAIDEN NAME OF MOTHER

Katherine Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Baltimore Md

14

Informant (Address)

JOHNS HOPKINS HOSPITAL

ROBERT A. KRAUTER

NOV 20 1922

19

Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from Nov 11, 1922, to Nov 19, 1922

that I last saw him alive on Nov 19, 1922

and that death occurred, on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH* was as follows:

Meningitis, Influenzal

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 14 ds.

Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Puncture

(Signed) Horton Casparis M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE-

DATE OF BURIAL

St. Redeemer Cemetery Nov 21, 1922

20 UNDERTAKER

Robt J. Turner Inc 1444 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69327

CERTIFICATE OF DEATH.

D69327

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

2-FULL NAME

(a) RESIDENCE. No.

(Usual place of abode)

Length of residence in city or town where death occurred

yrs.

mos.

22 ds.

How long in U. S., if of foreign birth?

yrs.

mos.

27 ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 Single, Married, Widowed, or Divorced (write the word)

Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

May 25 1907

7 AGE

Years

Months

Days

If LESS than
1 day, hrs.
or min.

15

5

25

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

School child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)San Jose
Costa Rica

10 NAME OF FATHER

Mr. O. F. Rohrmoser

11 BIRTHPLACE OF FATHER (city or town)
(State or country)Lev
Costa Rica

12 MAIDEN NAME OF MOTHER

Elena Lahmann

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

Costa Rica

14

Informant
(Address)O. F. Rohrmoser
San Jose, Costa Rica

15

NOV 20 1922

ROBERT R. KRAUTER
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov. 19, 1922

17

I HEREBY CERTIFY, That I attended deceased from
Oct. 28, 1922, to Nov. 19, 1922,

that I last saw her alive on Nov. 19, 1922,

and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

CONTRIBUTORY (Secondary) (duration) yrs. 2 mos. ds.

18 Where was disease contracted
if not at place of death?

Did an operation precede death?

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert E. Frucke, M.D.

19 (Address)

1418 Eutaw Place, Bal.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

San Jose Costa Rica

Nov 23 1922

20 UNDERTAKER

ADDRESS

Chas. G. Black 742 W. North Ave.

Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D69328

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. *Church Ave to St. 9* ST., *9* WARD)2-FULL NAME *Miss Tillie McWhirter (Matilda)*(a) RESIDENCE NO. *714 E. North Ave.* ST., WARD(Usual place of abode) Length of residence in city or town where death occurred *35* yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *White* 5 Single, Married, Widowed, or Divorced, (write the word) *Single*

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) *Aug. 25, 1887*7 AGE Years *35* Months *2* Days *24* If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work *None*

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) *Baltimore* (State or country) *Maryland*10 NAME OF FATHER *John J. McWhirter*11 BIRTHPLACE OF FATHER (city or town) *Baltimore* (State or country) *Maryland*12 MAIDEN NAME OF MOTHER *Elizabeth Lynch*13 BIRTHPLACE OF MOTHER (city or town) *Richmond* (State or country) *Virginia*14 Informant *Miss Helen C. McWhirter* (Address) *714 E. North Avenue*15 *NOV 20 1922* Filed *ROBERT R. KRAUTER* RegistrarBurial Permit *OK*

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) *Nov. 19 1922*17 I HEREBY CERTIFY, That I attended deceased from *Oct. 28*, 1922, to *Nov. 19*, 1922,that I last saw her alive on *Nov. 18*, 1922,and that death occurred, on the date stated above, at *12:40* m.

The CAUSE OF DEATH* was as follows:

Renal Tuberculosis
Miliary Tuberculosis
J. B. Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY *Pulmonary Tuberculosis* (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? *Not known*Did an operation precede death? *Not* Date of *8 yrs ago*Was there an autopsy? *Yes*What test confirmed diagnosis? *Autopsy Findings*(Signed) *Richard T. Hobbs* M. D., 19 (Address) *Church & Stone St. N.Y.*

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Cathedral Cemetery

DATE OF BURIAL

11/22 1922

20 UNDERTAKER

Henry W. Mears & Son 305 N. Calvert

Physicians should state EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D69329

D69329

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.

318 S. Spring ST. 3

REGISTERED NO. C.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME

Dorothy Young

(Residence in Baltimore: No.

318 S. Spring

St.; yrs., 8 mos., ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,

Female

4-COLOR OR RACE,

colored

5-SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED.
(Write the word.)

Single

6-DATE OF BIRTH,

April 15, 1922

(Month)

(Day)

(Year)

7-AGE,

8 yrs., 2 mos., 2 ds.

If LESS than 1 day,

hrs. or min.?

8-OCCUPATION:

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer).

None

9-BIRTHPLACE,
(State or Country),

Baltimore Md

PARENTS.

10-NAME OF FATHER,

Howard Young

11-BIRTHPLACE OF FATHER
(State or Country),

Md

12-MAIDEN NAME OF MOTHER

Sarah Whetten

13-BIRTHPLACE OF MOTHER
(State or Country),

Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).

Howard Young

(Address).

318 S. Spring

15

NOV 20 1922

ROBERT R. KRAUTER,

Filed.

191

Burial Permit 0.67

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH,

Nov 17, 1922

(Month)

(Day)

(Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 15 1922, to Nov 16 1922,

that I saw her alive on Nov 16 1922,

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(Duration) yrs. mos. ds.

(Signed) Nathan Helfsoff M. D.

(Address) 117 S. Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

Mt Auburn

DATE OF BURIAL,

Nov 21, 1922

UNDERTAKER

R B Cross 1405 McClellan St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D69330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D69330

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1902 Eutaw Place

ST., 14 WARD)

2. FULL NAME

Marie Kell Busick

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. #1902 Eutaw Place

ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S., if of foreign birth?

yrs.

mos.

ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word)

Female White Divorced

5a If married, widowed, or divorced

HUSBAND of (or) WIFE of

Howard Busick

6 DATE OF BIRTH (month, day, and year) Apr 20-1885

7 AGE

Years 37

Months 9

Days 28

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

Bon. Gas Elec Co

9 BIRTHPLACE (city or town) (State or country)

Balto

10 NAME OF FATHER

Fred Kell

11 BIRTHPLACE OF FATHER (city or town) (State or country)

Richmond Va

12 MAIDEN NAME OF MOTHER

Imma L. Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Balto

14

Informant (Address)

Mrs. Louis Peckler 5425 Park St

15

NOV 20 1922

ROBERT H. KRAUTH

Filed

19

Burial Permit Clerk

UNDERTAKER

Wm J. Tickner

19 PLACE OF BURIAL, CREMATION OR RE-MOVAL

London Park

DATE OF BURIAL

ADDRESS

Nov 20 1922

16 DATE OF DEATH (month, day, and year) Nov. 18th 1922

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 17th, 1922, to Nov. 18th, 1922

that I last saw her alive on Nov. 17th, 1922

and that death occurred, on the date stated above, at 5.45 A. M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) 24 hours. yrs. mos. ds.

CONTRIBUTORY Mitral Regurgitation (Secondary)

(duration) 12 yrs. - mos. - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. H. DeWall, M. D.

19 (Address) 1317 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)